



# Continuation of Coverage Election Notice

---

**(18-29 month qualifying events)**

**READ NOW**

**You have 60 days after the postmark  
to elect to continue your PEBB health coverage.**

## **PEBB contact information**

You may obtain information about PEBB eligibility and COBRA and other continuation coverage from:

**Mailing address**

Health Care Authority  
PEBB Benefit Services  
P.O. Box 42684  
Olympia, WA 98504-2684

**Street address**

Health Care Authority  
PEBB Benefit Services  
676 Woodland Square Loop SE  
Lacey, WA 98503

Phone: 1-800-200-1004 or 360-412-4200

PEBB Web site: **[www.pebb.hca.wa.gov](http://www.pebb.hca.wa.gov)**

You may find the Public Employees Benefits Board's existing laws in chapter 41.05 of the Revised Code of Washington (RCW), and rules in chapters 182-04, 182-08, 182-12, 182-13, and 182-16 of the Washington Administrative Code (WAC). These are available on the Office of the Code Reviser's Web site at **[slc.leg.wa.gov](http://slc.leg.wa.gov)**.

To obtain this document in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

# Table of Contents

---

Introduction .....	3
Important information about your continuation coverage rights .....	4
What is continuation coverage? .....	4
How to elect continuation coverage .....	5
Independent election rights .....	5
Electing COBRA or PEBB Extension of Coverage .....	5
Electing LWOP coverage .....	6
Electing PEBB-sponsored retiree coverage .....	7
Electing PEBB-sponsored retiree coverage as a surviving dependent .....	8
Special considerations in deciding whether to elect COBRA .....	8
How long will COBRA or other continuation coverage last? .....	9
Termination of COBRA and other continuation coverage options before the end of the maximum coverage period .....	13
How much does continuation coverage cost? .....	14
COBRA or PEBB Extension of Coverage .....	14
LWOP coverage .....	14
PEBB-sponsored retiree coverage .....	15
When and how do I make payments? .....	15
Other individuals who may be qualified dependents .....	16
For more information .....	17

*(continued on next page)*

# Table of Contents *(continued)*

---

Appendix A  
*COBRA and PEBB Extension of Coverage*

Appendix B  
*The Leave Without Pay (LWOP) Option*

Appendix C  
*PEBB-Sponsored Retiree Coverage*

# Introduction

**This notice contains important information about your right to continue your health care coverage in the Public Employees Benefits Board (PEBB) program.**

To elect continuation coverage, you must complete the appropriate enclosed election form and submit it to PEBB Benefit Services following the instructions in this notice. **If you do not elect to continue coverage, your PEBB coverage will end on the last day of the month you cease to be eligible under PEBB rules for coverage provided through your employer.**

**“You” in this notice refers to each person who will lose PEBB coverage.**

The event that caused you to lose PEBB coverage is called a “qualifying event” and the date of that event is the date of your qualifying event. Each “qualified beneficiary” (each person who lost PEBB coverage due to the qualifying event) is entitled to elect continuation coverage to continue PEBB coverage for 18-29 months.

If you choose continuation coverage, it will begin the first day of the month following the date your employer-provided coverage ended. (Employer-provided coverage ends the last day of the month you no longer meet the definition of employee in PEBB rules).

**You do not have to send payment with your election form; however, we will not enroll you until we receive your first payment. Additional information about payment for continuation coverage is included later in this notice.**

If you have questions about this notice or your rights to elect continuation coverage, please contact:

**Mailing address**

Health Care Authority  
PEBB Benefit Services  
P.O. Box 42684  
Olympia, WA 98504-2684

**Street address**

Health Care Authority  
PEBB Benefit Services  
676 Woodland Square Loop SE  
Lacey, WA 98503

Phone: 1-800-200-1004 or 360-412-4200

## Important information about your continuation coverage rights

Continuation coverage provides the same medical and dental benefits available to other PEBB enrollees, including (for example) copayments, deductibles, and choice of health plans. Each qualified dependent who elects continuation coverage will have the same rights as PEBB enrollees, including open enrollment and special enrollment rights.

### What is continuation coverage?

In this notice, “continuation coverage” refers to any of the following options you or your covered dependents may be eligible for to continue your PEBB coverage when it would otherwise end.

As a PEBB enrollee, you may be eligible for one or more of the following four continuation of coverage options:

- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
- PEBB Extension of Coverage
- Leave Without Pay (LWOP) coverage
- PEBB-sponsored retiree coverage

The first three options above temporarily extend group health coverage if certain circumstances occur that would otherwise end your or your dependents’ PEBB medical and dental coverage. COBRA continuation coverage is governed and administered by federal law and regulations. PEBB Extension of Coverage is an alternative created for PEBB enrollees who are not eligible for COBRA. LWOP coverage is an alternative that may be appropriate in specific situations.

The fourth option above is available only to individuals who meet eligibility criteria in Washington Administrative Code (WAC) 182-12-171, or surviving dependents who meet eligibility criteria in WAC 182-12-250 or 182-12-265.

The HCA administers all four options.

A summary of the eligibility requirements for each continuation coverage follows:

- If you are enrolled in PEBB health coverage and are a qualified beneficiary under federal law, and if you have a qualifying event, you may be eligible to continue your PEBB coverage under **COBRA**. (See Appendix A.)
- If you are enrolled in PEBB health coverage and are not a qualified beneficiary under federal law, and have a qualifying event, you will not be eligible for COBRA but may be eligible to continue your medical and/or dental coverage under **PEBB Extension of Coverage**. People who are not qualified beneficiaries under COBRA law include qualified same-sex domestic partners, children of same-sex domestic partners, COBRA beneficiaries who become entitled to Medicare, and retirees and their dependents who cease to be eligible for PEBB-sponsored retiree coverage. (See Appendix A.)
- If you are an employee who will lose your PEBB coverage because you are on authorized leave without pay from your agency, are laid off due to a reduction in force, are receiving time-loss benefits under workers’ compensation, are applying for disability retirement, have been called to active military duty, are on approved educational leave, are a part-time faculty or reversion employee, or are an employee awaiting appeal of dismissal, you may be entitled to **LWOP coverage**. LWOP coverage allows you and your eligible dependents to continue medical, dental, and

life insurance for at least 18 months (and in some instances, 29 months) as stated in WAC 182-12-133(1) and (2), 182-12-141, and 182-12-148. **Note:** In the case of approved educational leave, you may be entitled to continue long-term disability coverage as well. (See Appendix B.)

- If you are an employee who will lose your PEBB coverage because you are retiring, and meet PEBB eligibility criteria in WAC 182-12-171, you may be entitled to elect **PEBB-sponsored retiree coverage** to continue medical and dental coverage for you and your eligible dependents. You may also be entitled to enroll in PEBB-sponsored retiree term life insurance. (See Appendix C.)
- If you are a spouse, qualified same-sex domestic partner, or eligible child who will lose PEBB coverage due to the death of an eligible employee or PEBB retiree, you may be entitled to elect **PEBB-sponsored retiree coverage**. (See Appendix C.)
- If you are a spouse or eligible dependent of an emergency service employee killed in the line of duty as stated in WAC 182-12-250, you may be entitled to elect **PEBB-sponsored retiree coverage**. (See Appendix C.)

**If you do not elect continuation coverage within 60 days of the postmark on this notice, you will lose your right to elect any continuation coverage options.**

## **How to elect continuation coverage**

To elect continuation coverage, you must complete the election form of the continuation coverage you choose, follow the procedures included in this packet, and mail or hand-deliver it to PEBB Benefit Services by the deadline stated in this document. **If you don't, you will lose your right to elect COBRA or other continuation coverage.**

## **Independent election rights**

Each person who will lose PEBB coverage will have an independent right to elect COBRA or other continuation coverage. For example:

- The employee's spouse may elect continuation coverage, even if the employee does not.
- You may elect continuation coverage for only one, several, or all eligible dependent children.
- Covered employees and spouses (if the spouse is a qualified dependent) may elect continuation coverage on behalf of all of the qualified dependents, and parents may elect continuation coverage on behalf of their eligible children.

## **Electing COBRA or PEBB Extension of Coverage**

To elect COBRA or PEBB Extension of Coverage, you must complete the *COBRA Continuation or Extension of Coverage* form in Appendix A, and mail or hand-deliver it to PEBB Benefit Services. You have **60 days** after the date the *Continuation of Coverage Election Notice* is provided to you to elect COBRA or PEBB Extension of Coverage.

**Oral communications (in person or by telephone) and electronic communications (fax or e-mail) are not acceptable methods of elections, and will not preserve your COBRA or PEBB Extension of Coverage rights.**

**More information about COBRA and other continuation coverage is available in the *PEBB Initial Notice of COBRA and Continuation Coverage Rights*. This document is available online at [www.pebb.hca.wa.gov](http://www.pebb.hca.wa.gov) and from PEBB Benefit Services.**

If you are eligible for COBRA due to a qualifying event, you may elect medical and/or dental coverage from the plan(s) you were covered under on the day before the qualifying event. (For example, even if you had medical and dental coverage on the day before a qualifying event, you may elect COBRA for dental coverage only, medical coverage only, or both medical and dental.)

You may elect COBRA coverage even if you have other group health coverage or are entitled to Medicare on or before the date you elect COBRA coverage. Your COBRA coverage will terminate automatically if you become entitled to Medicare after you enroll. However, you may continue your health coverage for the remainder of your COBRA period through PEBB Extension of Coverage.

If you elect COBRA or PEBB Extension of Coverage, your coverage will also end early if you enroll in other group health coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied). See “Termination of COBRA and other continuation coverage options before the end of the maximum coverage period” section starting on page 13.

### **Electing LWOP coverage**

To elect the LWOP option, you must complete the *Leave Without Pay (LWOP) Continuation Coverage Election* form in Appendix B, and mail or hand-deliver it to PEBB Benefit Services. You have **60 days** after the date the *Continuation of Coverage Election Notice* is provided to you to elect LWOP coverage.

**Oral communications (in-person or by telephone) and electronic communications (fax or e-mail) are not acceptable methods of notifying us of your election, and will not preserve your LWOP coverage rights.**

If you qualify for LWOP coverage due to a qualifying event, you may elect medical, dental, and/or life insurance coverage from the plan(s) you were covered under on the day before the qualifying event. (For example, if you had medical, dental, and life insurance coverage on the day before a qualifying event, you may elect medical coverage only, dental coverage only, life insurance coverage only, or all three types of coverage.) If you were **not** covered under life insurance on the day before the qualifying event, you may **not** enroll in life insurance when electing LWOP coverage. **Note:** If you are on an approved educational leave, you may also elect to continue your long term disability (LTD) coverage for up to 24 months.

You may elect LWOP coverage even if you have other group health coverage or are entitled to Medicare on or before the date continuation coverage is elected.

## **Electing PEBB-sponsored retiree coverage**

To elect PEBB-sponsored retiree coverage, you must complete the *PEBB-Sponsored Retiree Coverage Election Form* in Appendix C, and mail or hand-deliver it to PEBB Benefit Services. You have **60 days** after the date the *Continuation of Coverage Election Notice* is provided to you to elect PEBB-sponsored retiree coverage.

**Oral communications (in person or by telephone) and electronic communications (fax or e-mail) are not acceptable methods of notifying us of your election, and will not preserve your PEBB-sponsored retiree coverage rights.**

If you meet the eligibility requirements in chapter 182-12 WAC, you may choose retiree medical and dental coverage, or medical coverage only, but you may **not** elect dental coverage only. If you were covered under the PEBB life insurance as an employee, you may elect retiree term life insurance. You may not enroll in dental coverage only unless you elect COBRA as described above.

Each person who will lose PEBB coverage due to your retirement has a separate right to elect continuation coverage. Your election options are described below:

- You and your eligible dependents (your spouse, qualified same-sex domestic partner, and eligible dependent children) may enroll in or defer PEBB retiree coverage. If you choose to enroll, your dependents will be enrolled in the same medical and dental plans and will have the same types of coverage that you have. (**Exception:** Your dependents may not enroll in retiree term life insurance.)

Choosing this option means that your qualified dependents will be electing PEBB retiree coverage instead of COBRA coverage. However, if there is a second qualifying event (such as a divorce or when a child no longer meets our definition of a dependent), your qualified dependents would still have the right to elect COBRA and continue PEBB coverage when they would otherwise lose PEBB-sponsored retiree coverage.

- If you defer enrollment in PEBB retiree coverage, your spouse and eligible dependent children still have the right to continue PEBB coverage by electing COBRA, as long as they follow the COBRA notice procedures described in this booklet.

You may elect PEBB-sponsored retiree coverage even if you have other group health coverage or are entitled to Medicare. **If entitled to Medicare, you must enroll in Medicare Part A and Part B.**

### **Electing PEBB-sponsored retiree coverage as a surviving dependent**

To elect PEBB-sponsored retiree coverage, you must complete the *PEBB-Sponsored Retiree Coverage Election Form* in Appendix C, and mail or hand-deliver it to PEBB Benefit Services. You must apply for surviving dependent coverage within **60 days** after the date of the death of the employee or retiree.

**Oral communications (in person or by telephone) and electronic communications (fax or e-mail) are not acceptable methods of notifying us of your elections, and will not preserve your PEBB-sponsored retiree coverage rights.**

If you are a spouse, qualified same-sex domestic partner, or eligible child who will lose PEBB coverage due to the death of an eligible PEBB employee or retiree, and you meet the requirements of WAC 182-12-265, you may elect to enroll in or defer PEBB retiree medical and dental coverage. (**Note:** Surviving spouses and dependent children of emergency service employees killed in the line of duty must meet the eligibility requirements in WAC 182-12-250.) You may **not** enroll in dental coverage only. Each qualified dependent (spouse, qualified same-sex domestic partner, and dependent child) who lost coverage due to the death of the employee or retiree has a separate right to elect PEBB-sponsored retiree coverage as a surviving dependent.

You may elect PEBB-sponsored retiree coverage even if you have other group health coverage or are entitled to Medicare. **If entitled to Medicare, you must enroll in Medicare Part A and Part B.**

### **Special considerations in deciding whether to elect COBRA**

In considering whether to elect COBRA, you should take into account that choosing **not** to elect COBRA will affect your future rights under federal law. Here are some examples of how you could be affected:

- You could lose the right to avoid having preexisting-condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. Election of COBRA may help you avoid such a gap.
- You lose the guaranteed right to purchase an individual health insurance policy that does not impose preexisting-condition exclusions if you do not get COBRA coverage for the maximum time available to you.
- You could lose the special enrollment rights granted to you by federal law. These rights include the right to request special enrollment in another group health plan you are eligible for (such as a plan sponsored by your spouse's employer) within 30 days after your PEBB coverage ends because of a qualifying event. If you enroll in COBRA for the maximum time available to you, you will also have the same special enrollment right at the end of your COBRA coverage.

If you are eligible for and elect to continue coverage under LWOP, the maximum number of months allowed under the federal COBRA law are included in the maximum number of months allowed under LWOP. (For example, if you are eligible for 29 months of LWOP coverage under PEBB rules, and eligible for 18 months of COBRA coverage because of your qualifying event, the first 18 months of LWOP coverage will satisfy the 18-month COBRA period.)

## **How long will COBRA or other continuation coverage last?**

**COBRA, PEBB Extension of Coverage, and the LWOP option** provide temporary continuation of coverage. The periods described below are maximum coverage periods. Coverage can end before the end of the maximum coverage period for any of the reasons described under “Termination of COBRA and other continuation coverage options before the end of the maximum coverage period” beginning on page 13.

*(1) When the qualifying event is death, divorce, legal separation, dissolution of a same-sex domestic partnership, or child's loss of dependent status*

- When PEBB coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, or when a dependent child is no longer eligible (as set forth in WAC 182-12-260), COBRA coverage can last up to 36 months.
- When PEBB coverage is lost due to the death of the employee, the covered employee's dissolution of a same-sex domestic partnership, or a dependent child of a qualified same-sex domestic partnership is no longer eligible (as set forth in WAC 182-12-260), PEBB Extension of Coverage can last up to 36 months.

*(2) When the qualifying event is death of an employee or retiree*

Surviving dependents who meet PEBB eligibility criteria (as set forth in WAC 182-12-250 and 182-12-265) may be eligible to continue coverage under PEBB-sponsored retiree coverage for the maximum period described below:

- The spouse or qualified same-sex domestic partner may continue coverage until death.
- The dependent children may continue coverage until they are no longer eligible (as set forth in WAC 182-12-260).

*(3) When the covered employee becomes entitled to Medicare within 18 months before his or her termination of employment or reduction of hours*

When PEBB coverage is lost due to the end of employment or reduction in the employee's hours, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, continuation coverage for qualified dependents (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement.

For example, if a covered employee becomes entitled to Medicare eight months before the date employment terminates, continuation of PEBB medical and dental coverage for the spouse or qualified same-sex domestic partner and children who lost coverage as a result can last up to 36 months after the date of Medicare entitlement. This equals 28 months after the date of the qualifying event (36 months minus eight months).

This continuation coverage period is available only if the covered employee becomes entitled to Medicare 18 months or less **before** termination of employment or reduction of hours.

*(4) When the qualifying event is a termination of employment or reduction of hours*

When PEBB coverage is lost due to the end of employment or reduction of the employee's hours, continuation coverage generally can last for up to 18 months subject to other provisions in this booklet.

*(5) Limited right to a maximum of 29 months for employees on approved LWOP*

When PEBB coverage is lost because of one of the following events, continuation coverage generally can last for a maximum of 29 months as set forth in WAC 182-12-133(1) and described below:

- You are on an authorized leave without pay from your agency.
- You are laid off because of a reduction in force (RIF).
- You are receiving time-loss benefits under workers' compensation.
- You are applying for disability retirement.
- You are called to active military duty (employees called to active military duty may continue their PEBB medical and/or dental coverage for up to 29 months, and PEBB life insurance for 12 months).
- You are on approved educational leave (employees on educational leave may continue their PEBB medical and/or dental coverage for up to 29 months, and PEBB long-term disability for a maximum of 24 months).

*(6) Limited right to an extension of the COBRA or LWOP coverage period*

An extension of the maximum 18-month period of continuation coverage available under COBRA or LWOP coverage may be available if you or a qualified dependent becomes disabled or a second qualifying event occurs.

You must notify PEBB Benefit Services of a disability or a second qualifying event to extend the period of continuation coverage. If you don't notify us of a disability or second qualifying event, you will lose the right to extend your continuation coverage. These extension opportunities do **not** apply to continuation coverage

**If you do not follow these procedures or provide written notice to PEBB Benefit Services within 60 days (during the 18-month continuation of coverage period), you will lose your right to a disability extension.**

resulting from a covered employee's death, divorce or legal separation, dissolution of a same-sex domestic partnership, or a dependent child's loss of eligibility.

*(a) Disability extension of COBRA, PEBB Extension of Coverage, or LWOP coverage*

If the Social Security Administration determines that you or a qualified dependent is disabled and you notify PEBB Benefit Services within the time periods below, all of the qualified dependents in your family may be entitled to receive up to 11 months of additional continuation coverage (for a total of 29 months). This extension is available only to those dependents who are receiving continuation coverage because of a qualifying event (the covered employee's termination of employment or reduction of hours).

The disability must have started before the 61<sup>st</sup> day after the covered employee's termination of employment or reduction of hours, and must last at least until the end of the continuation coverage period available without the disability extension (generally 18 months, as described above). Each qualified dependent will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if you notify PEBB Benefit Services in writing within **60 days** after the last of the following events:

- The date of the Social Security Administration's disability determination.
- The date of the covered employee's termination of employment or reduction of hours.
- The date the qualified dependent loses (or would lose) coverage under PEBB rules as a result of the covered employee's termination of employment or reduction of hours.

To request a disability extension, you must send written notice and a copy of your disability award letter from the Social Security Administration to PEBB Benefit Services.

*(b) Second qualifying-event extension of COBRA, PEBB Extension of Coverage, or LWOP coverage.*

An extension of COBRA, PEBB Extension of Coverage, or LWOP coverage may be available to spouses, qualified same-sex domestic partners, and dependent children who are receiving continuation coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension or for some LWOP coverage enrollees, 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months.

**If you do not follow these procedures or provide written notice to PEBB Benefit Services during the 60-day notice period, then there will be no extension of coverage due to a second qualifying event.**

of hours. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months.

Second qualifying events may include the death of a covered employee, divorce or legal separation, dissolution of a qualified same-sex domestic partnership, or a dependent child's ceasing to be eligible for coverage under PEBB rules. These events can be a second qualifying event only if they would have caused the qualified dependent to lose coverage under PEBB rules if the first qualifying event had not occurred.

Extension of coverage due to a second qualifying event is available only if you notify PEBB Benefit Services in writing of the second qualifying event within **60 days** after the last of the following events:

- The date of the second qualifying event.
- The date the qualified dependent would lose coverage under PEBB rules as a result of the second qualifying event (if it had occurred while the qualified dependent was still covered under the PEBB plan).

You may also need to send appropriate forms or supporting documentation when you notify PEBB Benefit Services. Call PEBB Benefit Services to ask what information they need.

**PEBB-sponsored retiree coverage** provides coverage for eligible retirees, eligible dependents of retirees, and surviving dependents of employees, retirees, and emergency service personnel killed in the line of duty. The coverage periods described below are maximum coverage periods. Coverage can end before the end of the maximum coverage period for several reasons, as described in the "Termination of COBRA and other continuation coverage options before the end of the maximum coverage period on page 13.

*1) When the qualifying event is retirement*

Employees who meet PEBB eligibility may be eligible to continue coverage under PEBB-sponsored retiree coverage until death.

*(2) When the qualifying event is the death of an employee or retiree*

Surviving dependents who meet PEBB eligibility (as set forth in WAC 182-12-265) may be eligible to continue coverage under PEBB-sponsored retiree coverage for the maximum periods described below:

- The spouse or qualified same-sex domestic partner may continue coverage until death.
- The dependent children may continue coverage until they are no longer eligible (as set forth in WAC 182-12-260).

*(3) When the qualifying event is death of an emergency service employee killed in the line of duty*

Surviving dependents who meet PEBB eligibility (as outlined in WAC 182-12-250) may be eligible to continue coverage under PEBB-sponsored retiree coverage for the maximum periods described below:

- The spouse may continue coverage until death.
- The dependent children may continue coverage until they are no longer eligible (as set forth in WAC 182-12-260).

**Termination of COBRA and other continuation coverage options before the end of the maximum coverage period**

*(1) Automatic termination before the end of the maximum coverage period*

COBRA and other continuation coverage options will automatically terminate before the end of the maximum period if:

- (a)* Any required premium is not paid in full on time.
- (b)* After electing COBRA or PEBB Extension of Coverage, a qualified dependent becomes covered under another group health plan (but only after any preexisting condition exclusions of the other plan have been exhausted or satisfied) and the qualified dependent is not continuing benefits under PEBB LWOP or retiree coverage.
- (c)* A qualified beneficiary becomes entitled to Medicare benefits (Part A, Part B, or both) after electing COBRA; however, he or she will be eligible to continue coverage under the PEBB Extension of Coverage option until the end of his or her original COBRA period.
- (d)* The employer ceases to provide any group health plan for its employees (this is particularly important for people eligible through an employer group such as a political subdivision).
- (e)* During a disability extension period, the disabled qualified dependent is determined by the Social Security Administration to be no longer disabled. (For more information about the disability extension period, see the “Limited right to an extension of the COBRA or LWOP coverage period” section starting on page 10.)
- (f)* If a dismissal is upheld, all coverage will terminate at the end of the month the decision is entered or the date through which premiums have been paid, whichever is earlier.
- (g)* Continuation coverage may also be terminated for any reason coverage would terminate for any other PEBB enrollee (such as fraud).

*(2) Medicare entitlement or other coverage*

You must notify PEBB Benefit Services in writing within **60 days** if, after electing continuation coverage, you or a qualified dependent becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health coverage (but only after any preexisting condition exclusions of that other plan have been exhausted or satisfied for your qualified dependent's preexisting condition).

Along with your written notice, please send a copy of the Medicare card. If the Social Security Administration denies enrollment in Medicare, send a copy of the denial letter.

If you enroll in other group health coverage, please send a copy of your enrollment letter.

*(3) You must notify PEBB Benefit Services if a qualified dependent ceases to be disabled*

If the Social Security Administration determines that a disabled qualified dependent is no longer disabled, you must notify PEBB Benefit Services in writing within **60 days**.

Along with your written notice, please send a copy of the Social Security Administration letter that states the dependent is no longer disabled.

*(4) Termination of COBRA, PEBB Extension of Coverage, or LWOP coverage when a qualified dependent ceases to be disabled*

If the Social Security Administration determines the qualified dependent is no longer disabled during a disability extension period, then COBRA, PEBB Extension of Coverage, or LWOP coverage for all qualified dependents will end on the date the determination was made, even if that date has passed.

You must repay all benefits paid after the termination date, even if you notify PEBB Benefit Services of the determination.

For more information about the disability extension period, see "Limited right to an extension of the COBRA or LWOP coverage period" beginning on page 10.

## **How much does continuation coverage cost?**

### **COBRA or PEBB Extension of Coverage**

The amount you pay may not exceed 102 percent (or, for COBRA coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for similar coverage for a participant who is not receiving COBRA coverage. The monthly premiums for PEBB medical and dental plans are in Appendix A.

### **LWOP coverage**

You pay 100 percent of the cost to the group health plan (including both employer and employee contributions) for similar coverage for

a participant who is not receiving LWOP coverage. The monthly premiums for medical, dental, life, and LTD coverage are in Appendix B.

### **PEBB-sponsored retiree coverage**

The monthly premiums for medical, dental, and retiree term life insurance are in Appendix C.

## **When and how do I make payments?**

### *(1) How to make premium payments*

You must pay all continuation coverage premiums by check, electronic funds transfer, or pension deduction. Make checks payable to the Washington State Treasurer. Your first payment and all monthly payments for continuation coverage must be mailed or hand-delivered to:

<b>Mailing address</b>	<b>Street address (for hand deliveries)</b>
Health Care Authority PEBB Program P.O. Box 34270 Seattle, WA 98124-1270	Health Care Authority PEBB Program 676 Woodland Square Loop SE Lacey, WA 98503

### *(2) When premium payments are considered made*

We consider your payment made when it is received by PEBB Accounting at one of the addresses above. Payment will not be considered made if your check is returned due to insufficient funds or for any other reason.

### *(3) First payment for continuation coverage*

If you elect to continue PEBB coverage, you do not have to send payment with the PEBB election form. However, you must make your first payment for continuation coverage no later than **45 days** after the date you elect coverage. This is the date your PEBB election form is received by PEBB.

Your first payment must cover the cost of continuation coverage from the time your PEBB coverage would have otherwise terminated up through the end of the month prior to when you make your first payment. For example: Sue's employment terminates on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her first premium payment covers the premiums for October and November and is due by December 30, the 45<sup>th</sup> day after the date of her COBRA election.

**You must make sure the amount of your first payment is correct. You may contact PEBB Benefit Services to confirm the amount due.**

**We will not enroll you until you have elected to continue your PEBB coverage *and* made the first payment.**

### *(4) Monthly payments for continuation coverage*

After you make your first payment for continuation coverage, you make regularly monthly payments to continue your coverage.

**If you do not pay the full amount due within 45 days after the date you elect coverage, you will lose all rights to COBRA or other PEBB continuation coverage options. We will not make any exceptions to this on-time payment rule.**

The amount due each month is shown in this notice. Payment for continuation coverage is due on the 15<sup>th</sup> day of the month for that month's coverage. If you make a monthly payment on or before the 15<sup>th</sup> day of the current month, your PEBB coverage will continue for that month without any break.

You may not be billed for your continuation coverage premium. Depending on your payment method, we may send you periodic statements as a reminder of your responsibility to pay your premiums on time. You must pay your premiums on time, even if we do not send you a periodic statement. You will lose all rights to COBRA and other PEBB continuation coverage if you don't follow the payment instructions in this section.

**If you fail to make a monthly payment before the end of the grace period, you will lose all rights to COBRA or other PEBB continuation coverage. No exceptions will be made for payments received after the end of this grace period.**

*(5) Grace periods for monthly premium payments*

Although monthly payments are due on the 15<sup>th</sup> day of each month of continuous coverage, we will give you a 30-day grace period to make each monthly payment. Your PEBB continuation coverage will continue as long as payment for the current month is made before the end of the grace period.

**Other individuals who may be qualified dependents**

*(1) Children born to or placed for adoption with the covered employee during a period of continuation coverage*

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA or other continuation coverage is considered a qualified dependent if the employee has elected COBRA or other continuation coverage for himself or herself.

The child's COBRA coverage begins when the child is enrolled in PEBB coverage, whether through special enrollment or open enrollment. Coverage lasts for as long as the continuation coverage for the employee's other family members.

To qualify to enroll in PEBB, the child must meet all other applicable PEBB eligibility requirements (for example, regarding age). See WAC 182-12-260(3), (4), and (5).

*(2) Alternate recipients under a Qualified Medical Child Support Order (QMCSOs)*

A child of the covered employee who is receiving PEBB benefits due to a QMCSO received by PEBB Benefit Services is entitled to the same rights to elect COBRA or other continuation coverage as an eligible dependent child of the covered employee.

### **Notify PEBB Benefit Services of address changes**

To protect your rights and the rights of your family, you should keep PEBB Benefit Services informed of address changes for all family members. You should also keep a copy of any notices you send to the HCA for your records.

### **For more information**

This notice does not fully describe your rights under COBRA or other continuation coverage. More information is available in the *PEBB Initial Notice of COBRA and Continuation of Coverage Rights*, on the PEBB Web site, or from PEBB Benefit Services. Questions concerning your PEBB eligibility should also be addressed to PEBB Benefit Services.

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other federal laws affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at **[www.dol.gov/ebsa](http://www.dol.gov/ebsa)**. (Addresses and phone numbers of regional and district EBSA offices are available through EBSA's Web site.)



# Appendix A

## (COBRA and PEBB Extension of Coverage)

---

**Complete this *COBRA Continuation or Extension of Coverage* form if the qualifying event is one of the following:**

### **Employee:**

- Your employment ends for any reason other than gross misconduct.
- Your hours of employment were reduced.
- If you are appealing a dismissal, contact your payroll or benefits office to continue coverage under the Leave Without Pay (LWOP) option.

### **Spouse:**

- Your spouse (the employee or retiree) dies.
- Your spouse's (the employee's) hours of employment are reduced other than his or her gross misconduct.
- Your spouse's (the employee's) employment ends for any reason other than gross misconduct.
- You become divorced or legally separated from your spouse. Also, if your spouse (the employee or retiree) reduces or eliminates your Public Employees Benefits Board (PEBB) medical or dental coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

### **Dependent child:**

- Your parent (the employee or retiree) dies.
- Your parent's (the employee's) hours of employment are reduced.
- Your parent's (the employee's) employment ends for any reason other than his or her gross misconduct.
- You stop being eligible for PEBB coverage as a dependent child. (See WAC 182-12-260(3), (4), and (5).)

### **Retiree:**

- You are a retiree and your employer group terminated plan participation.
- You are a retiree and the Department of Retirement Systems has determined that you are no longer disabled, so your pension has stopped.

### **Same-sex domestic partner:**

- Your same-sex domestic partner (the employee or retiree) dies.
- Your same-sex domestic partner's (the employee's) hours of employment are reduced.
- Your same-sex domestic partner's (the employee's) employment ends for any reason other than gross misconduct.
- You are the same-sex domestic partner of an employee or retiree, or the partner's covered dependent, and the domestic partnership is dissolved.

# COBRA Continuation or Extension of Coverage Election

---

## Instructions

To elect COBRA or PEBB extension of coverage, complete this *COBRA Continuation or Extension of Coverage* form and mail or hand-deliver it to PEBB Benefit Services.

**Mail to:**

Health Care Authority  
PEBB Benefit Services  
P.O. Box 42684  
Olympia, WA 98504-2684

**Hand-deliver to:**

Health Care Authority  
PEBB Benefit Services  
676 Woodland Square Loop SE  
Lacey, WA 98503

You have **60 days** after the postmarked date of this *Continuation of Coverage Election Notice* to decide whether you want to elect COBRA.

**Oral communications (in person or by telephone) and electronic communications (fax or e-mail) are not acceptable methods of election, and will not preserve your COBRA rights.**

**If you do not submit a completed *COBRA Continuation or Extension of Coverage* form by this due date, you will lose your right to elect COBRA or PEBB Extension of Coverage.**

Read the important information about your rights in the *Continuation of Coverage Election Notice* which includes this *COBRA Continuation or Extension of Coverage* form.

# Public Employees Benefits Board (PEBB)

## 2007 COBRA Continuation or Extension of Coverage

- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- **We must receive your first payment before you can be enrolled.** (Make checks payable to the Washington State Treasurer.)
- Attach appropriate dependent certification forms if required (students age 20 through age 23, extended dependents, and dependents with disabilities.) Forms are available at [www.pebb.hca.wa.gov](http://www.pebb.hca.wa.gov).

<b>Retiree Information ONLY</b>	Retiree name			
	Retiree social security number		Date employer coverage ended (mm/dd/yyyy)	

**I/we elect COBRA continuation coverage as indicated below:**

**Section 1: SUBSCRIBER INFORMATION**

Social security number	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last name	First name	Middle initial
Address				Apt./unit number
City	State	ZIP Code	County of residence	
Date of birth (mm/dd/yyyy)	Work phone number (including area code) ( )	Home phone number (including area code) ( )		
The medical plans marked with an asterisk (*) in Section 4 assign a physician or clinic code to their providers and require you to choose a primary care provider. Contact your plan for code.				Physician or clinic code

**Select coverage you wish to continue:** ☐ Medical/Dental ☐ Medical only  
☐ **Cancel all coverage** Reason \_\_\_\_\_ Date of event \_\_\_\_\_

**Are you covered by another group medical or dental plan?** ☐ Yes ☐ No Effective date \_\_\_\_\_

**Are you disabled under Title II (OASDI) of the Social Security Act?** ☐ Yes ☐ No Effective date \_\_\_\_\_

**Are you disabled under Title XVI (SSI) of the Social Security Act?** ☐ Yes ☐ No Effective date \_\_\_\_\_

**If yes, you must send a copy of your Social Security Disability Award letter.**

**Are you enrolled in Part(s) A and/or B of Medicare?** Part A (hospital) ☐ Yes ☐ No Effective date \_\_\_\_\_  
Part B (medical) ☐ Yes ☐ No Effective date \_\_\_\_\_

**Note:** If you are enrolled in Medicare Part(s) A and/or B, you must send a copy of your Medicare card(s) along with this form.

**Are you enrolled in Part D of Medicare?** ☐ Yes ☐ No Effective date \_\_\_\_\_

**Section 2: SPOUSE OR SAME-SEX DOMESTIC PARTNER INFORMATION** *List only eligible family members.*

Social security number	Date of marriage or partnership criteria met (mm/dd/yyyy)	Physician or clinic code	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)
Address (if different from subscriber)		City	State ZIP Code

**Select coverage you wish to continue:** ☐ Medical/Dental ☐ Medical only  
☐ **Cancel all coverage** Reason \_\_\_\_\_ Date of event \_\_\_\_\_

**Are you covered by another group medical or dental plan?** ☐ Yes ☐ No Effective date \_\_\_\_\_

**Are you disabled under Title II (OASDI) of the Social Security Act?** ☐ Yes ☐ No Effective date \_\_\_\_\_

**Are you disabled under Title XVI (SSI) of the Social Security Act?** ☐ Yes ☐ No Effective date \_\_\_\_\_

**If yes, you must send a copy of your Social Security Disability Award letter.**

**Are you enrolled in Part(s) A and/or B of Medicare?** Part A (hospital) ☐ Yes ☐ No Effective date \_\_\_\_\_  
Part B (medical) ☐ Yes ☐ No Effective date \_\_\_\_\_

**Note:** If you are enrolled in Medicare Part(s) A and/or B, you must send a copy of your Medicare card(s) along with this form.

**Are you enrolled in Part D of Medicare?** ☐ Yes ☐ No Effective date \_\_\_\_\_

**Section 3: FAMILY MEMBER INFORMATION** Use additional forms for more members. List only eligible family members.

<b>A</b>	Relationship to subscriber	Social security number	Physician or clinic code	<input type="checkbox"/> Disabled? <input type="checkbox"/> Student? <small>Check only if age 20 or older.</small>	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Last name		First name		Middle initial	Date of birth (mm/dd/yyyy)
Address (if different from subscriber)		City		State	ZIP Code
Select coverage you wish to continue: <input type="checkbox"/> Medical/Dental <input type="checkbox"/> Medical only <input type="checkbox"/> Cancel all coverage    Reason _____    Date of event _____					
Are you covered by another group medical or dental plan?			<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective date _____	
Are you disabled under Title II (OASDI) of the Social Security Act?			<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective date _____	
Are you disabled under Title XVI (SSI) of the Social Security Act?			<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective date _____	
If yes, you must send a copy of your Social Security Disability Award letter.					
Are you enrolled in Part(s) A and/or B of Medicare?			Part A (hospital) <input type="checkbox"/> Yes <input type="checkbox"/> No	Effective date _____	
			Part B (medical) <input type="checkbox"/> Yes <input type="checkbox"/> No	Effective date _____	
Note: If you are enrolled in Medicare Part(s) A and/or B, you must send a copy of your Medicare card(s) along with this form.					
Are you enrolled in Part D of Medicare?			<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective date _____	

<b>B</b>	Relationship to subscriber	Social security number	Physician or clinic code	<input type="checkbox"/> Disabled? <input type="checkbox"/> Student? <small>Check only if age 20 or older.</small>	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Last name		First name		Middle initial	Date of birth (mm/dd/yyyy)
Address (if different from subscriber)		City		State	ZIP Code
Select coverage you wish to continue: <input type="checkbox"/> Medical/Dental <input type="checkbox"/> Medical only <input type="checkbox"/> Cancel all coverage    Reason _____    Date of event _____					
Are you covered by another group medical or dental plan?			<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective date _____	
Are you disabled under Title II (OASDI) of the Social Security Act?			<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective date _____	
Are you disabled under Title XVI (SSI) of the Social Security Act?			<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective date _____	
If yes, you must send a copy of your Social Security Disability Award letter.					
Are you enrolled in Part(s) A and/or B of Medicare?			Part A (hospital) <input type="checkbox"/> Yes <input type="checkbox"/> No	Effective date _____	
			Part B (medical) <input type="checkbox"/> Yes <input type="checkbox"/> No	Effective date _____	
Note: If you are enrolled in Medicare Part(s) A and/or B, you must send a copy of your Medicare card(s) along with this form.					
Are you enrolled in Part D of Medicare?			<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective date _____	

<b>Section 4: MEDICAL PLAN SELECTION</b> (Check only one.)	<b>Section 5: DENTAL PLAN SELECTION</b> (Check only one.)
<div> <input type="checkbox"/> Community Health Plan Classic  <input type="checkbox"/> Group Health Classic  <input type="checkbox"/> Group Health Value  <input type="checkbox"/> Kaiser Permanente Classic  <input type="checkbox"/> Kaiser Permanente Value  <input type="checkbox"/> Medicare Supplement Plan E, administered by Premera Blue Cross  <input type="checkbox"/> Medicare Supplement Plan J, administered by Premera Blue Cross  <input type="checkbox"/> Regence Classic*  <input type="checkbox"/> Secure Horizons Classic* (Medicare enrollees only)  <input type="checkbox"/> Secure Horizons Value* (Medicare enrollees only)  <input type="checkbox"/> Uniform Medical Plan           </div> <div> <i>*These plans require the physician or clinic code of your selected primary care provider. You may find the code in the provider directory on our Web site or by calling the plan.</i> </div>	<div> <b>Preferred Provider Organization</b>  <input type="checkbox"/> Uniform Dental Plan (Group #3000)                (may receive services from any provider)  <b>Managed Care Plans</b>  <input type="checkbox"/> DeltaCare (Group #3100)                Dentist name _____                (must receive services from DeltaCare provider)  <input type="checkbox"/> Regence BlueShield Columbia Dental Plan                Clinic location _____                (must receive services from Willamette Dental Group provider)  <b>Note:</b> Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.           </div>

**Section 6: SIGNATURE** (Required)

Insurance coverage is determined through verification of eligibility by PEBB Benefit Services. I declare that to the best of my knowledge and belief my family members and I are eligible for the coverage requested. This form supersedes all forms and submissions I have previously made for coverage. A premium deposit does not guarantee coverage and will be returned if I am determined to be ineligible for coverage.

Washington State law may require disclosure of any information you submit as a public record. The HCA's Privacy Notice is available upon request by calling 360-923-2822 or online at [www.hca.wa.gov](http://www.hca.wa.gov).

Subscriber's signature \_\_\_\_\_ Date \_\_\_\_\_



Visit our Web site at [www.pebb.hca.wa.gov](http://www.pebb.hca.wa.gov)

**Please sign and date this form.**

**Return to:**

Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684

**If payment enclosed, return to:**

Washington State Health Care Authority, P.O. Box 42695, Olympia, WA 98504-2695

For Agency Use Only	<input type="checkbox"/> 18-month (Terminated or reduction in hours)	<input type="checkbox"/> 29-month (Approved disability [SSI])	<input type="checkbox"/> 36-month (Spouse/child: loss of dependent eligibility)
---------------------	--	---	---

# 2007 PEBB COBRA and Extension of Coverage Monthly Rates

Effective January 1, 2007

## Special Requirements

1. To qualify for the Medicare rate, you must be enrolled in both Part A and Part B of Medicare.
2. Medicare-enrolled subscribers in Group Health Cooperative's Medicare Advantage plan, Kaiser Permanente Senior Advantage, or Secure Horizons must agree to complete and sign the *Medicare Advantage Plan Election Form* to enroll in one of these plans. For more information on these requirements, please contact your health plan's customer service department.

Medical Plans									
Subscribers not eligible for Medicare (or enrolled in Part A only):	Community Health Plan Classic	Group Health Classic	Group Health Value	Kaiser Permanente Classic	Kaiser Permanente Value	Regence Classic	Secure Horizons Classic	Secure Horizons Value	Uniform Medical Plan
<b>Subscriber Only</b>	\$ 480.75	\$ 435.92	\$ 390.81	\$ 448.72	\$ 409.12	\$ 518.98	N/A	N/A	\$ 401.66
<b>Subscriber &amp; Spouse</b>	954.12	864.46	774.25	890.06	810.87	1,030.58	N/A	N/A	795.94
<b>Subscriber &amp; Child(ren)</b>	835.78	757.33	678.39	779.73	710.43	902.68	N/A	N/A	697.36
<b>Full Family</b>	1,309.15	1,185.87	1,061.83	1,221.07	1,112.18	1,414.28	N/A	N/A	1,091.64
Subscribers enrolled in Part A & Part B of Medicare:									
<b>Subscriber Only</b>	\$ 440.02	\$ 335.70	\$ 303.02	\$ 312.80	\$ 239.80	\$ 520.16	\$ 331.68	\$ 254.58	\$ 342.72
<b>Subscriber &amp; Spouse (1 eligible)</b>	913.39	764.25	686.46	754.15	641.55	1,031.76	N/A	N/A	737.00
<b>Subscriber &amp; Spouse (2 eligible)</b>	872.66	664.03	598.67	618.23	472.23	1,032.94	655.99	501.79	678.07
<b>Subscriber &amp; Child(ren) (1 eligible)</b>	795.05	657.11	590.60	643.81	541.11	903.86	N/A	N/A	638.43
<b>Subscriber &amp; Child(ren) (2 eligible)</b>	872.66	664.03	598.67	618.23	472.23	1,032.94	655.99	501.79	678.07
<b>Full Family (1 eligible)</b>	1,268.42	1,085.66	974.04	1,085.16	942.86	1,415.46	N/A	N/A	1,032.71
<b>Full Family (2 eligible)</b>	1,227.69	985.44	886.25	949.24	773.54	1,416.65	N/A	N/A	973.77
<b>Full Family (3 eligible)</b>	1,305.30	992.36	894.32	923.66	704.66	1,545.73	980.30	749.00	1,013.41

## Medicare Supplement Plans

	Premera Blue Cross					
	Plan E Retired	Plan E Disabled	Plan J Retired with Rx**	Plan J Disabled with Rx**	Plan J Retired without Rx	Plan J Disabled without Rx
<b>Subscriber Only</b>	\$ 122.12	\$ 207.61	\$ 273.22	\$ 464.47	\$ 163.40	\$ 277.77
<b>Subscriber &amp; Spouse (1 eligible)*</b>	523.78	609.27	674.88	866.13	565.06	679.43
<b>Subscriber &amp; Spouse (2 eligible - 1 retired, 1 disabled)</b>	329.73	329.73	737.69	737.69	441.17	441.17
<b>Subscriber &amp; Spouse (2 eligible)</b>	244.24	415.22	546.44	928.94	326.80	555.54
<b>Subscriber &amp; Child(ren)*</b>	425.21	510.70	576.31	767.56	466.49	580.86
<b>Full Family (1 eligible)*</b>	819.49	904.98	970.59	1,161.84	860.77	975.14
<b>Full Family (2 eligible - 1 retired, 1 disabled)*</b>	632.82	632.82	1040.78	1040.78	744.26	744.26
<b>Full Family (2 eligible)*</b>	547.33	718.31	849.53	1,232.03	629.89	858.63

\* If a Medicare supplement plan is selected, non-Medicare eligible dependents are enrolled in the Uniform Medical Plan (UMP). The rates shown reflect the total rate due, including both the Medicare supplement and the UMP premiums.

\*\* Plan J with Rx is no longer offered to new subscribers.

<b>Dental Plans with Medical Plan</b>	DeltaCare, administered by Washington Dental Service	Regence BlueShield Columbia Dental Plan	Uniform Dental Plan
<b>Subscriber Only</b>	\$ 34.03	\$ 40.49	\$ 39.36
<b>Subscriber &amp; Spouse</b>	68.05	80.99	78.72
<b>Subscriber &amp; Child(ren)</b>	68.05	80.99	78.72
<b>Full Family</b>	102.08	121.48	118.09

<b>Dental Plans Dental Only</b>	DeltaCare, administered by Washington Dental Service	Regence BlueShield Columbia Dental Plan	Uniform Dental Plan
<b>Subscriber Only</b>	\$ 41.40	\$ 47.87	\$ 46.74
<b>Subscriber &amp; Spouse</b>	75.43	88.36	86.10
<b>Subscriber &amp; Child(ren)</b>	75.43	88.36	86.10
<b>Full Family</b>	109.46	128.86	125.46

# PEBB Life Insurance Conversion

When you terminate your employment or retire, you are entitled to convert your Public Employees Benefits Board (PEBB)-sponsored group life insurance policy to an individual whole life policy. You may do this *without providing proof of good health* when your coverage ends or is reduced under the group plan sponsored by the PEBB. You can also convert the group life coverage on your family members to individual whole life policies for each covered dependent. See your PEBB life insurance booklet for further details or call a customer service representative at ReliaStar Life Insurance Company (1-866-689-6990).

To apply for conversion of your group life insurance, fill out and mail the bottom part of this form to ReliaStar Life Insurance Company. **To protect your right of conversion, this form must be postmarked no later than 31 days (if you are terminating**

**employment) or 60 days (if you are retiring) following the date your group coverage terminates.** When your application is received by ReliaStar, you should expect to receive the company's conversion application within 15 days.

Provided that you apply on time and pay your first premium, the converted policy will take effect either 31 days (for terminating employees) or 60 days (for retiring employees) after the date of termination of your group coverage. **You are covered by the group plan during the 31-day or 60-day conversion period, as long as premiums are paid.** You will be billed directly by ReliaStar Life Insurance Company for all premium payments retroactive to the date your group term life coverage ended. In addition, the company will provide all policy service you may require directly. The Health Care Authority will not be involved.



## For terminating or retiring employees of PEBB-sponsored plans

I am interested in the conversion option described in my Group Insurance Certificate. Please furnish information and the necessary forms.			
Employee's name		Social security number — —	Date of birth
Spouse's/same-sex domestic partner's name (Complete only if you are interested in converting his or her insurance.)			Date of birth
Phone number	State agency or institution		<b>Reason for Conversion</b> <input type="checkbox"/> Retiring      Date _____ <input type="checkbox"/> Resigning      Date _____ <input type="checkbox"/> Other      Date _____ If other, state reason _____ _____
Address		Apt./unit number	
City, county, state, and ZIP Code			
<b>Note:</b> If you are disabled and qualify for the waiver of premium benefit, check this box. <input type="checkbox"/>			
Date	Signature		

Washington State law may require disclosure of any information you submit as a public record.  
The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or  
online at [www.pebb.hca.wa.gov](http://www.pebb.hca.wa.gov).



HCA 50-540 (11/04)

**Please return to:**  
ReliaStar Life Insurance Company  
P.O. Box 20 - Route 7325  
Minneapolis, MN 55440-0020



# Appendix B (the LWOP Option)

**Complete this *LWOP Continuation Coverage Election* form if you are an employee or the eligible dependent of an employee who will lose your **PEBB** coverage because of one of the following events:**

- You are on authorized leave without pay from your agency.
- You are laid off because of a reduction in force (RIF).
- You are receiving time-loss benefits under workers' compensation.
- You are applying for disability retirement.
- You are called to active military duty.
- You are on approved educational leave.
- You are a part-time faculty member between periods of eligibility.
- You are an employee who reverted to a position that is not eligible for employer-sponsored benefits.
- You are an employee awaiting hearing of a dismissal action.
- You are a seasonal employee between seasons of employment.

**Instructions**

To elect LWOP coverage, complete this *Leave Without Pay (LWOP) Continuation Coverage Election* form and return it to PEBB Benefit Services.

<b>Mail to (if no payment enclosed):</b> Health Care Authority PEBB Benefit Services P.O. Box 42684 Olympia, WA 98504-2684	<b>Mail to (if payment enclosed):</b> Washington State Health Care Authority P.O. Box 42695 Olympia, WA 98504-2695	<b>Hand-deliver to:</b> Health Care Authority PEBB Benefit Services 676 Woodland Square Loop SE Lacey, WA 98503
--	--	---

To elect LWOP coverage, you must complete the *Leave Without Pay (LWOP) Continuation Coverage Election* form in this Appendix B, and submit it to PEBB Benefit Services. Under federal law, you have **60 days** after the postmarked date of this *Continuation of Coverage Election Notice* to decide whether you want to elect LWOP coverage.

The *Leave Without Pay (LWOP) Continuation Coverage Election* form must be completed and mailed or hand-delivered to PEBB Benefit Services at the address specified in this notice.

**Oral communications (in person or by telephone) and electronic communications (fax or e-mail) are not acceptable methods of elections, and will not preserve your LWOP continuation coverage rights.**

**If you do not submit a completed *Leave Without Pay (LWOP) Continuation Coverage Election* form by this due date, you will lose your right to elect LWOP continuation coverage.**

Read the important information about your rights in the *Continuation of Coverage Election Notice (18-29 month qualifying events)*, which includes this *Leave Without Pay (LWOP) Continuation Coverage Election* form.

## Read the following information carefully before completing the form.

### Medical and dental benefits

You and your dependents may make a separate election. You may continue medical coverage only, both medical and dental, or dental coverage only on a self-pay basis. You are not allowed to change medical or dental plans at the time you choose to continue your benefits on a self-paid basis. You will be allowed to change health plans only during an open enrollment period or when you move out of your plan's service area.

### Life insurance benefits

You may continue all or part of your life insurance coverage. If you choose to continue any part of your optional life coverage, you must also continue the \$25,000 basic coverage at a cost of \$4.30 per month.

If you self-pay for a reduced amount of optional coverage, you must reapply to increase your life insurance coverage when you return to active employment. Please note the following:

1. If you continue Part B Spouse Supplemental coverage, you must also continue Part B Basic Spouse coverage. The amount of Part B Spouse Supplemental coverage continued while you self-pay cannot exceed the coverage you had as an active employee.
2. If you are called to active military duty, you may extend life insurance coverage Parts A, B, C, and D to the end of the 12th calendar month in which your active duty began. You cannot continue Part E life insurance. If you do not choose to continue your life insurance under one of the following options, all life insurance, including basic life insurance paid by your employer, will end at the end of the month in which you begin active duty. There are two options for extending insurance benefits:
  - a. You can use agency-approved annual or military leave to maintain a minimum of eight hours pay status each month. Employer-sponsored life insurance Part A will be continued. You are responsible for paying the premium for continued coverage of Parts B, C, and D.
  - b. You can self-pay your life insurance coverage by completing the life insurance section of the *Leave Without Pay (LWOP) Continuation Coverage Election* form.
3. If you return to full-time employment status before the end of the 12th calendar month in which you began active duty, you may reinstate your original coverage without proof of insurability. If you return to full-time employment status after the end of the 12th month in which you began active duty, you may be required to provide proof of insurability to obtain coverage under Parts B, C, and D. Upon your return to work, any increase to the amount of life insurance you had in place when you were called to active duty will require proof of insurability.

When you return to work, you will need to complete the *Life Insurance Enrollment/Change Form* within 31 days in both situations to reinstate your employer-sponsored and optional coverages:

- a. If you choose to self-pay optional coverage during a leave without pay, coverage will be reinstated as an active employee when you return to work without providing evidence of insurability.
- b. If you choose not to pay for optional coverage or if you reduced your coverage during LWOP, you will have to submit evidence of insurability when you return to work.

### **Long-term disability benefits**

**Neither basic nor optional long-term disability (LTD) coverage may be continued by self-payment unless you are on approved educational leave.** Your personnel, payroll, or benefits office has a definition of educational leave for this purpose. If you qualify for continuation of LTD coverage and choose to do so, you must pay the \$2.45 premium for basic LTD coverage if you want to continue under the optional LTD plan.

Optional LTD coverage dropped during a leave without pay will be reinstated when you return to work without providing evidence of insurability.



Public Employees Benefits Board (PEBB)

# 2007 Leave Without Pay (LWOP) Continuation Coverage Election

- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- List **only** eligible family members you wish to enroll.
- **We must receive your first payment before you can be enrolled.** (Make checks payable to the Washington State Treasurer.)
- Attach appropriate **dependent certification** forms if required (students age 20 through age 23, extended dependents, and dependents with disabilities.) Forms are available at [www.pebb.hca.wa.gov](http://www.pebb.hca.wa.gov).

<b>Section 1: SUBSCRIBER INFORMATION</b>				Date employer coverage ended	
Social security number	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last name	First name	Middle initial	
Address					Apt./unit number
City	State	ZIP Code	County of residence		
Date of birth (mm/dd/yyyy)	Work phone number (including area code) ( )		Home phone number (including area code) ( )		
The medical plan marked with an asterisk (*) in Section 4 assigns a physician or clinic code to its providers and requires you to choose a primary care provider. Contact your plan for code.					Physician or clinic code
Are you part-time faculty? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Select coverage you wish to continue: <input type="checkbox"/> Medical/Dental <input type="checkbox"/> Medical only <input type="checkbox"/> Dental only <input type="checkbox"/> Life insurance <input type="checkbox"/> Long-term disability (only if on educational leave)					
<input type="checkbox"/> Cancel all coverage Reason _____ Date of qualifying event _____					
Are you covered by another group medical or dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date _____					
*Note: If you are enrolled in Medicare Part(s) A and/or B, <b>attach a copy</b> of your Medicare card(s) along with this form.					

<b>Section 2: SPOUSE OR SAME-SEX DOMESTIC PARTNER INFORMATION</b> <i>List only eligible family members.</i>				
Social security number	Date of marriage (mm/dd/yyyy)	Physician or clinic code	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)	
Address (if different from subscriber)		City	State	ZIP Code
Select coverage you wish to continue: <input type="checkbox"/> Medical/Dental <input type="checkbox"/> Medical only <input type="checkbox"/> Dental only				
<input type="checkbox"/> Cancel all coverage Reason _____ Date of qualifying event _____				
Are you covered by another group medical or dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date _____				
*Note: If you are enrolled in Medicare Part(s) A and/or B, <b>attach a copy</b> of your Medicare card(s) along with this form.				

<b>Qualifying event</b> (please check one)		
<input type="checkbox"/> Applying for disability retirement	<input type="checkbox"/> Reversion employee	<input type="checkbox"/> Approved educational leave
<input type="checkbox"/> Reduction in force (RIF)	<input type="checkbox"/> Approved leave without pay (LWOP)	<input type="checkbox"/> Seasonal employment
<input type="checkbox"/> Part-time faculty reduction in hours	<input type="checkbox"/> Workers' compensation	<input type="checkbox"/> Other _____
<input type="checkbox"/> Military leave (provide date called to duty _____ )		



Visit our Web site at [www.pebb.hca.wa.gov](http://www.pebb.hca.wa.gov)

**Section 3: FAMILY MEMBER INFORMATION**

(Such as child, grandchild, etc.) **Use additional forms for more members.**  
List **only** eligible family members you wish to enroll.

Relationship to subscriber	Social security number	Physician or clinic code	<input type="checkbox"/> Disabled? <input type="checkbox"/> Student?	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Last name		First name	Middle initial	Date of birth (mm/dd/yyyy)
Address (if different from subscriber)		City	State	ZIP Code

Select coverage you wish to continue: ☐ Medical/Dental ☐ Medical only ☐ Dental only

☐ Cancel all coverage Reason \_\_\_\_\_ Date of qualifying event \_\_\_\_\_

Are you covered by another group medical or dental plan? ☐ Yes ☐ No Effective date \_\_\_\_\_

**\*Note:** If you are enrolled in Medicare Part(s) A and/or B, **attach a copy** of your Medicare card(s) along with this form.

**Section 4: MEDICAL PLAN SELECTION**

(Check only one.)

- ☐ Community Health Plan Classic
- ☐ Group Health Classic
- ☐ Group Health Value
- ☐ Kaiser Permanente Classic
- ☐ Kaiser Permanente Value
- ☐ Regence Classic\*
- ☐ Uniform Medical Plan

**\*This plan requires the physician or clinic code of your selected primary care provider. You may find the code in the provider directory on our Web site or by calling the plan.**

**Section 5: DENTAL PLAN SELECTION**

(Check only one.)

**Preferred Provider Organization**

- ☐ Uniform Dental Plan (Group #3000)  
(may receive services from any provider)

**Managed Care Plans**

- ☐ DeltaCare (Group #3100)  
Dentist name \_\_\_\_\_  
(must receive services from DeltaCare provider)
- ☐ Regence BlueShield Columbia Dental Plan  
Clinic location \_\_\_\_\_  
(must receive services from Willamette Dental Group provider)

**Note:** Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.

**Section 6: LIFE INSURANCE****Current Enrollment with Agency****Coverage Amount**

- ☒ Basic Part A (\$4.30/month) \$25,000
- ☐ Part B – Dependent/Children \_\_\_\_\_
- ☐ Part B – Spouse \_\_\_\_\_
- ☐ Part B – Supplemental Spouse \_\_\_\_\_
- ☐ Part C \_\_\_\_\_
- ☐ Part D \_\_\_\_\_
- ☐ Part E with Dependents \_\_\_\_\_
- ☐ Part E without Dependents \_\_\_\_\_

**Desired Enrollment while Self-Paying**

- ☐ I wish to maintain the same coverage I had as an active employee. (initials) \_\_\_\_\_
- ☐ I do not wish to continue the life coverage while eligible for self-pay; I understand that I must reapply and submit evidence of insurability to reinstate optional life insurance when I return to work. (initials) \_\_\_\_\_

**Section 7: LONG-TERM DISABILITY**

This section applies **ONLY** to employees on **educational leave**.

**Current Enrollment with Agency**

- ☒ Basic (\$2.45/month)
- ☐ 30–Day ☐ 120–Day ☐ 300–Day
- ☐ 60–Day ☐ 180–Day ☐ 360–Day
- ☐ 90–Day ☐ 240–Day

**Desired Enrollment while Self-Paying**

- ☐ I wish to maintain the same coverage I had as an active employee. (initials) \_\_\_\_\_
- ☐ I do not wish to maintain the same coverage I had as an active employee. (initials) \_\_\_\_\_

**Section 8: SIGNATURE** (Required)

Insurance coverage is determined through verification of eligibility by PEBB Benefit Services. I declare that to the best of my knowledge and belief my family members and I are eligible for the coverage requested. This form supersedes all forms and submissions I have previously made for coverage. A premium deposit does not guarantee coverage and will be returned if I am determined to be ineligible for coverage.

Washington State law may require disclosure of any information I submit as a public record. The HCA's Privacy Notice is available upon request by calling 360-923-2822 or online at [www.hca.wa.gov](http://www.hca.wa.gov).

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Return to:**  
Washington State Health Care Authority  
P.O. Box 42684  
Olympia, WA 98504-2684

**If payment enclosed, return to:**  
Washington State Health Care Authority  
P.O. Box 42695  
Olympia, WA 98504-2695

# 2007 PEBB LWOP Monthly Rates

Effective January 1, 2007

Rates for employees in a leave-without-pay (LWOP) or reduction-in-force (RIF) situation (Medicare rates are not available to these subscribers).

<b>Medical Plans</b>							
Subscribers not eligible for Medicare (or enrolled in Part A only):	Community Health Plan Classic	Group Health Classic	Group Health Value	Kaiser Permanente Classic	Kaiser Permanente Value	Regence Classic	Uniform Medical Plan
<b>Subscriber Only</b>	\$ 471.32	\$ 427.37	\$ 383.15	\$ 439.92	\$ 401.10	\$ 508.80	\$ 393.78
<b>Subscriber &amp; Spouse</b>	935.41	847.51	759.07	872.61	794.97	1,010.37	780.33
<b>Subscriber &amp; Child(ren)</b>	819.39	742.48	665.09	764.44	696.50	884.98	683.69
<b>Full Family</b>	1,283.48	1,162.62	1,041.01	1,197.13	1,090.37	1,386.55	1,070.24

<b>Dental Plans with Medical Plan</b>	DeltaCare, administered by Washington Dental Service	Regence BlueShield Columbia Dental Plan	Uniform Dental Plan
<b>Subscriber Only</b>	\$ 33.36	\$ 39.70	\$ 38.59
<b>Subscriber &amp; Spouse</b>	66.72	79.40	77.18
<b>Subscriber &amp; Child(ren)</b>	66.72	79.40	77.18
<b>Full Family</b>	100.08	119.10	115.77

<b>Dental Plans Dental Only</b>	DeltaCare, administered by Washington Dental Service	Regence BlueShield Columbia Dental Plan	Uniform Dental Plan
<b>Subscriber Only</b>	\$ 40.59	\$ 46.93	\$ 45.82
<b>Subscriber &amp; Spouse</b>	73.95	86.63	84.41
<b>Subscriber &amp; Child(ren)</b>	73.95	86.63	84.41
<b>Full Family</b>	107.31	126.33	123.00

For information, contact the Health Care Authority at 1-800-200-1004.



# Appendix C (PEBB-Sponsored Retiree Coverage)

## Complete the **PEBB-Sponsored Retiree Coverage Election Form** if your **PEBB coverage will end because of one of the following events:**

- You are an employee who is retiring and eligible for PEBB-sponsored retiree coverage as set forth in WAC 182-12-171.
- You are a surviving spouse, qualified same-sex domestic partner, or dependent child of a deceased eligible employee or retiree, and eligible for PEBB-sponsored retiree coverage as set forth in WAC 182-12-265.
- You are the spouse or dependent child of an emergency service employee killed in the line of duty, and eligible for PEBB-sponsored retiree coverage as set forth in WAC 182-12-250.

**Note:** When you enroll in retiree coverage, the monthly premiums, medical plans available in your county, and benefits may change, depending on the plan you choose. For more information, refer to the *Retiree Enrollment Guide*. You can find this online at [www.pebb.hca.wa.gov](http://www.pebb.hca.wa.gov) or request a copy by calling PEBB Benefit Services at 1-800-200-1004.

Locate your plan choice in the columns below and complete the appropriate form(s).

Form A	Forms A and C	Forms A and B
Community Health Plan Classic Group Health Classic Group Health Value Kaiser Permanente Classic Kaiser Permanente Value Regence Classic Uniform Medical Plan	Group Health Medicare Advantage Classic Group Health Medicare Advantage Value Kaiser Permanente Senior Advantage Classic Kaiser Permanente Senior Advantage Value Secure Horizons Classic Secure Horizons Value	Medicare Supplement Plan E* Medicare Supplement Plan J*  <i>*Administered by Premiera Blue Cross</i>
Please note: If you're adding a <b>qualified same-sex domestic partner</b> to your coverage and completing Form B or C, same-sex domestic partners need to use the "spouse" sections.		

To enroll some eligible dependents, you may need to complete and attach other forms to the following retiree form. These forms are available online at [www.pebb.hca.wa.gov](http://www.pebb.hca.wa.gov) or by calling PEBB Benefit Services.

### To add this dependent:

### Complete and attach this form:

Spouse or qualified same-sex domestic partner	<i>Spouse or Same-Sex Domestic Partner Certification</i>
Dependent age 20 through age 23	<i>Student Certification/Change</i>
Dependent with disabilities	<i>Certification of Dependents With Disabilities</i>
Dependent who is not your biological child, adopted child, or stepchild	<i>Extended Dependent Certification</i>

# PEBB-Sponsored Retiree Coverage Election Form

**Instructions**

To elect PEBB-sponsored retiree coverage, complete the *PEBB-Sponsored Retiree Coverage Election Form* and return it to PEBB Benefit Services.

<b>Mail to (if payment not enclosed):</b> Health Care Authority PEBB Benefit Services SE P.O. Box 42684	<b>Mail to (if payment enclosed):</b> Washington State Health Care Authority P.O. Box 42695  Olympia, WA 98504-2695	<b>Hand-deliver to:</b> Health Care Authority PEBB Benefit Services 676 Woodland Square Loop  Lacey, WA 98503
---	--	--

To elect PEBB-sponsored retiree coverage, you must complete this *PEBB-Sponsored Retiree Coverage Election Form* in this appendix, and submit it to PEBB Benefit Services. You have **60 days** after the postmarked date of this *Continuation of Coverage Election Notice* to decide whether you want to elect PEBB-sponsored retiree coverage.

The *PEBB-Sponsored Retiree Coverage Election Form* must be completed and mailed or hand-delivered to PEBB Benefit Services at the address specified in this notice. **Oral communications (in person or by telephone) and electronic communications (e-mail or fax) are not acceptable methods of election and will not preserve your COBRA or PEBB-sponsored retiree coverage rights.**

**If you do not submit a completed *COBRA Continuation Coverage Election form* or *PEBB-Sponsored Retiree Coverage Election Form* by this due date, you will lose your right to elect COBRA or other continuation coverage (including PEBB-sponsored retiree coverage).**

Read the important information about your rights in the *Continuation of Coverage Election Notice*, which includes this *PEBB-Sponsored Retiree Coverage Election Form*.

Public Employees Benefits Board (PEBB)


# PEBB-Sponsored Retiree Coverage Election Form

- List all eligible family members you wish to enroll on this form.
- If deferring PEBB retiree coverage, complete sections 1 and 9.
- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- Attach appropriate **dependent certification** form(s) if required (students age 20 through age 23, extended dependents, and dependents with disabilities). Forms are available at [www.pebb.hca.wa.gov](http://www.pebb.hca.wa.gov).
- If re-enrolling after deferment, you must attach proof of continuous medical coverage since your date of deferment.
- If you are a surviving spouse or dependent, provide the social security number of the deceased retiree in Section 1 SSN area.

<b>Retiree or employee information ONLY</b>	Retiree or employee name		Retirement system
	Retiree or employee social security number		Retirement date (mm/dd/yyyy)
<b>For K-12 school district retirees only</b>	School district	When does your current <b>school district</b> medical/dental <b>coverage end?</b> (mm/dd/yyyy)	
<b>Re-enrollment after deferment</b>	Date other coverage ended (mm/dd/yyyy)		

## Section 1: Subscriber Information

Social security number	Last name	First name	Middle initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address	Apt./Unit number	City	State	ZIP Code
County of residence	Date of birth (mm/dd/yyyy)	Work phone number (including area code) (       )	Home phone number (including area code) (       )	

The medical plans marked with a "+" in Section 5 assign a physician or clinic code to their providers and require you to choose a primary care provider. **Contact your plan or go to the Provider Directory on our Web site for the code.**  Physician or clinic code

## Election

**Medical Coverage**    ☐ Enroll:    ☐ Medical only    ☐ Medical and dental

☐ Re-enrollment after deferment (You must provide proof of continuous coverage.) Date other coverage ended \_\_\_\_\_

☐ Defer (due to enrollment in employer coverage) **If deferring, see Section 9. Note: This defers coverage for all family members.**

☐ Defer (due to enrollment in a federal retiree program)

☐ Defer (due to Medicare–Medicaid with creditable coverage)

☐ Terminate: I understand that I am forfeiting all further rights to enroll in the PEBB program.

Date you want coverage to end \_\_\_\_\_

**Are you enrolled in Part(s) A and/or B of Medicare?**    **Part A (hospital)** ☐ Yes ☐ No    If yes, effective date \_\_\_\_\_  
**If yes, attach a copy** of your Medicare card to this election form.

**Part B (medical)** ☐ Yes ☐ No    If yes, effective date \_\_\_\_\_

**Are you enrolled in Part D of Medicare?** ☐ Yes ☐ No    If yes, effective date \_\_\_\_\_

**Are you receiving Medicare disability?** ☐ Yes ☐ No    If yes, effective date \_\_\_\_\_  
**If yes, attach a copy** of your Social Security Disability Award letter.

**Section 2: Spouse or Same-Sex Domestic Partner**

List only family members you wish to cover; family members cannot be enrolled in any other PEBB coverage.

**Relationship to subscriber** If adding a spouse or partner, please attach a completed *Spouse or Same-Sex Domestic Partner Certification* form.

☐ **Spouse:** date of marriage \_\_\_\_\_ ☐ **Same-sex domestic partner:** date criteria met \_\_\_\_\_

Social security number	Last name	First name	Middle initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address (if different from subscriber)		City	State	ZIP Code
Date of birth (mm/dd/yyyy)	Physician or clinic code			

**Notice of Qualifying Event (see below)**

**Medical** ☐ Enroll Reason: \_\_\_\_\_  
**Coverage** ☐ Waive ☐ Loss of student status ☐ Married ☐ Other (explain) \_\_\_\_\_  
☐ Terminate ☐ Loss of dependent status through divorce, legal separation, or dissolution of a qualified same-sex domestic partnership  
☐ Attained age that is no longer eligible for PEBB coverage  
Date of qualifying event \_\_\_\_\_

**Are you enrolled in Part(s) A and/or B of Medicare?** **Part A (hospital)** ☐ Yes ☐ No If yes, effective date \_\_\_\_\_  
If yes, attach a copy of your Medicare card to this election form.

**Part B (medical)** ☐ Yes ☐ No If yes, effective date \_\_\_\_\_

**Are you enrolled in Part D of Medicare?** ☐ Yes ☐ No If yes, effective date \_\_\_\_\_

**Are you receiving Medicare disability?** ☐ Yes ☐ No If yes, effective date \_\_\_\_\_  
If yes, attach a copy of your Social Security Disability Award letter.

**Section 3: Family Member Information** (such as a child, grandchild, etc.) *Use additional forms for more members.*

<b>1</b>	Relationship	Last name	First name	Middle initial
Social security number	Date of birth (mm/dd/yyyy)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Disabled? <input type="checkbox"/> Student? <i>Check only if age 20 or older.</i>	Physician or clinic code
Address (if different from subscriber)		City	State	ZIP Code

**Notice of Qualifying Event (see below)**

**Medical** ☐ Enroll Reason: \_\_\_\_\_  
**Coverage** ☐ Waive ☐ Loss of student status ☐ Married ☐ Other (explain) \_\_\_\_\_  
☐ Terminate ☐ Loss of dependent status through divorce, legal separation, or dissolution of a qualified same-sex domestic partnership  
☐ Attained age that is no longer eligible for PEBB coverage  
Date of qualifying event \_\_\_\_\_

**Are you enrolled in Part(s) A and/or B of Medicare?** **Part A (hospital)** ☐ Yes ☐ No If yes, effective date \_\_\_\_\_  
If yes, attach a copy of your Medicare card to this election form.

**Part B (medical)** ☐ Yes ☐ No If yes, effective date \_\_\_\_\_

**Are you enrolled in Part D of Medicare?** ☐ Yes ☐ No If yes, effective date \_\_\_\_\_

**Are you receiving Medicare disability?** ☐ Yes ☐ No If yes, effective date \_\_\_\_\_  
If yes, attach a copy of your Social Security Disability Award letter.

(continued on next page)

**Section 3: Family Member Information continued** (such as a child, grandchild, etc.) *Use additional forms for more members.*

<b>2</b>	Relationship	Last name	First name	Middle initial
	Social security number	Date of birth (mm/dd/yyyy)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Disabled? <input type="checkbox"/> Student? Physician or clinic code <i>Check only if age 20 or older.</i>
Address (if different from subscriber)		City	State	ZIP Code

**Notice of Qualifying Event (see below)**

**Medical Coverage** ☐ Enroll ☐ Waive ☐ Terminate Reason:  
☐ Loss of student status ☐ Married ☐ Other (explain) \_\_\_\_\_  
☐ Loss of dependent status through divorce, legal separation, or dissolution of a qualified same-sex domestic partnership  
☐ Attained age that is no longer eligible for PEBB coverage  
Date of qualifying event \_\_\_\_\_

**Are you enrolled in Part(s) A and/or B of Medicare?** **Part A (hospital)** ☐ Yes ☐ No If yes, effective date \_\_\_\_\_  
If yes, attach a copy of your Medicare card to this election form. **Part B (medical)** ☐ Yes ☐ No If yes, effective date \_\_\_\_\_

**Are you enrolled in Part D of Medicare?** ☐ Yes ☐ No If yes, effective date \_\_\_\_\_

**Are you receiving Medicare disability?** ☐ Yes ☐ No If yes, effective date \_\_\_\_\_  
If yes, attach a copy of your Social Security Disability Award letter.

**Section 4: Additions or Changes** *Check all that apply.*

**Retiree changed:** ☐ Name ☐ Address ☐ Medical plan ☐ Dental plan

**Change in family status:**

☐ Adding a spouse or qualified same-sex domestic partner

You **must** complete a *Spouse or Same-Sex Domestic Partner Certification* form, available from the Health Care Authority or online at [www.pebb.hca.wa.gov](http://www.pebb.hca.wa.gov).

☐ Adding family member 1 (from Section 3)

☐ Adding family member 2 (from Section 3)

**Section 5: Medical Plan Selection** *Check only one.*

- |  |   |
|--|---|
| <input type="checkbox"/> Community Health Plan Classic | <input type="checkbox"/> Medicare Supplement Plan E, administered by Premiera Blue Cross* |
| <input type="checkbox"/> Group Health Classic          | <input type="checkbox"/> Medicare Supplement Plan J, administered by Premiera Blue Cross* |
| <input type="checkbox"/> Group Health Value            | <input type="checkbox"/> Regence Classic <sup>†</sup>                                     |
| <input type="checkbox"/> Kaiser Permanente Classic     | <input type="checkbox"/> Secure Horizons Classic <sup>† ‡</sup>                           |
| <input type="checkbox"/> Kaiser Permanente Value       | <input type="checkbox"/> Secure Horizons Value <sup>† ‡</sup>                             |
|  | <input type="checkbox"/> Uniform Medical Plan   |

\* You must fill out Form "B" for this Plan.

<sup>†</sup> These plans require the physician or clinic code of your selected primary care provider. Contact your plan or go to the Provider Directory on our Web site for the code.

<sup>‡</sup> These plans offer Medicare Advantage plans available only to Medicare enrollees where available. Complete and attach the *Medicare Advantage Plan Election Form* (form C).

**Section 6: Dental Plan Selection** *Check only one.***Preferred Provider Organization**

- ☐ Uniform Dental Plan (Group #3000)  
(may receive services from any provider)

**Note: Delta Dental is the parent company of Washington Dental Services (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.**

**Managed Care Plans**

- ☐ DeltaCare (Group #3100)  
Dentist name or clinic code \_\_\_\_\_  
(must receive services from DeltaCare provider)
- ☐ Regence BlueShield Columbia Dental Plan  
Clinic location \_\_\_\_\_  
(must receive services from Willamette Dental Group Provider)

- ☐ **Cancel Dental**  
I understand ☐  
cover ☐

## Section 7: Life Insurance Enrollment Information

Retiree Term Life Insurance is **only available** to those who received PEBB employee life insurance. Application for Retiree Term Life Insurance must be made at the time of retirement. The cost is \$2.19 per month regardless of age.

I hereby elect to enroll in the PEBB Retiree Term Life Insurance Plan. ☐ Yes ☐ No

Disabled retirees who qualify for the waiver of premium benefit under the PEBB employee life insurance plan are not eligible for this Retiree Term Life Insurance Plan.

Age at Time of Death	Amount of Coverage
Under 65	\$3,000
65 through 69	\$2,100
70 and over	\$1,800

Beneficiary \_\_\_\_\_ Beneficiary's SSN \_\_\_\_\_

Relationship to retiree \_\_\_\_\_ Beneficiary's date of birth \_\_\_\_\_

Beneficiary's address \_\_\_\_\_

## Section 8: Authorization for Enrollment and/or Premium

I authorize ☐

☐ Yes, deduct from my pension

☐ No, I will send my payment monthly (**Note:** You must make the first payment before you will be enrolled. Make checks payable to the Washington State Treasurer.)

## Section 9: Signature *Required*

By submitting this form, I understand that I am responsible for the

repayment of any

premium if I am determined by the Washington State Health Care Authority (HCA) to be ineligible for coverage.

fail to update this information in accordance with eligibility guidelines. A deposit of premium does not guarantee coverage and will be refunded if I am determined by the Washington State Health Care Authority (HCA) to be ineligible for coverage.

**If deferring coverage, I certify and understand the following provisions:**

In order ☐

to maintain continuous enrollment in employer-sponsored coverage to HCA during an annual open enrollment or within 60 days of the date the other coverage ends.

If deferring ☐

coverage, I must submit an enrollment form and proof of continuous enrollment in a federal-sponsored retiree medical plan to HCA during an annual open enrollment or within 60 days of the date the other coverage ends.

This form supersedes all forms and submissions I have previously made for PEBB coverage.

Washington State law may require disclosure of any information I submit as public record. The HCA's privacy notice is available upon request by calling 360-923-2822 or online at [www.hca.wa.gov](http://www.hca.wa.gov).

Retiree signature \_\_\_\_\_ Date \_\_\_\_\_



**Washington State  
Health Care Authority**  
*Public Employees Benefits Board*

### Return form to:

Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684

**Be sure to sign and date this form.**

**Note:** If you or your dependents are entitled to Medicare, you must be enrolled in **Medicare Parts A and B**. If you haven't done so already, please send a copy of the Medicare card(s) along with this form.



**SECTION 1 – APPLICANT INFORMATION**

Your Social Security Number (must include) □□□-□□-□□□□			Spouse Social Security Number (if applying) □□□-□□-□□□□		
Your Last Name	First Name	Initial	Spouse Last Name	First Name	Initial
Date of Birth (month/day/year) / /		<input type="checkbox"/> Male <input type="checkbox"/> Female	Spouse Date of Birth (month/day/year) / /		<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address (cannot be a P.O. box)			City	State	ZIP
Billing Address (if different from above; not applicable to PEBB/K-12 retirees)			City	State	ZIP
Mailing Address (if different from above addresses)			City	State	ZIP
Phone Number ( )		Medicare Supplement Plan Desired <input type="checkbox"/> Plan E <input type="checkbox"/> Plan J			
<p>The Health Care Authority sets the effective date for PEBB/K-12 retirees. For all other applicants, coverage starts on the first of the month after the application postmark date, if all information is completed and accurate, and you meet the eligibility requirements in Section 2 below. To request a later effective date (no more than 90 days from postmark date), state residents should write that date here: ____/01/____.</p> <p>If you are replacing a Medicare Advantage plan, you must request to delay the effective date until after the date your Medicare Advantage coverage ends. If you need help with this, please contact us at 1-800-817-3049.</p>					

**SECTION 2 – ELIGIBILITY**

**Public Employees Benefit Board (PEBB) and K-12 Retirees**

To be eligible, you must be either an eligible PEBB or K-12 retiree or the eligible spouse of such a retiree. You must also be covered by Part A (Hospital Insurance) and Part B (Medical Insurance) of Medicare. You must enroll within one of the time limits below. Please check the time limit that applies to you. Your spouse may enroll with you even if one of the events below does not apply to your spouse.

**Check one; fill in the blank if needed.**

- ☐ In the 30-day period before you become eligible for Part A and B of Medicare
- ☐ Within 60 days of retirement. Retirement date: \_\_\_\_\_
- ☐ Within six months of initial enrollment in Medicare Part B
- ☐ Within six months after attaining age 65
- ☐ During an open enrollment period, if any, established by HCA for PEBB and K-12 retirees, only if you are transferring from another health plan with no lapse in coverage. Note: Existing PEBB and K-12 subscribers may change their coverage by applying for another program offered by the HCA only at the HCA's next open enrollment period for PEBB and K-12 retirees.

## All Other Applicants

To be eligible, you must be a current Washington State resident. You must also be covered by Part A (Hospital Insurance) and Part B (Medical Insurance) of Medicare. You must enroll within one of the enrollment time limits below. Please check the time limit that applies to you. Your spouse may enroll with you even if one of the events below does not apply to your spouse.

If you are under 65, and your enrollment in Parts A and B of Medicare was more than six months from the date of this application, please provide a copy of your Award Notice from Social Security.

### Check one; fill in the blank if needed.

- ☐ Within 60 days of establishing Washington State residency. Resident date: \_\_\_\_\_
- ☐ In the 30-day period before you become eligible for Part A and B of Medicare
- ☐ Within 60 days of retirement. Retirement date: \_\_\_\_\_
- ☐ Within six months of initial enrollment in Medicare Part B
- ☐ Within six months after attaining age 65
- ☐ During an open enrollment period, if any, established by HCA for persons who are not PEBB or K-12 retirees, only if you are transferring from another health plan with no lapse in coverage.

## Additional Application Periods for All Eligible Applicants

1. You can also apply for the HCA Plan E or J if one of the two conditions below is true.
  - a. You left the HCA Plan E or J to try a Medicare Advantage program (including Medicare HMO or PPO programs), PACE program, or Medicare Cost, Risk, or SELECT program for the first time. You may apply if you tried one program, more than one program of the same type, or more than one type of program. However, all four statements must be true:
    - You were covered under each program you tried for less than 12 months.
    - Each program (other than the most recent) was terminated voluntarily.
    - You switched programs within 63 days of the date the prior program terminated, with no other coverage in between.
    - The effective date of the last program you tried was less than 24 months after the effective date of the first program you tried.
  - b. If you are applying for the HCA Plan E and J offered only to people who have Medicare by reason of age, you can also apply if, at age 65 and first becoming eligible for Medicare Part A, you enrolled in one or more PACE programs or Medicare Advantage programs (including Medicare HMO or PPO programs). All four statements in part "a." above must also be true.
2. You can also apply for the HCA Plan E coverage if one of the conditions below is true.
  - a. You lose retiree group coverage.
  - b. Your Medicare supplement coverage ended because the carrier became bankrupt or insolvent.
  - c. You were covered under a Medicare SELECT, Advantage, Risk or Cost program, or a PACE program, and your coverage ended or will end for one of the following reasons:
    - The program was withdrawn in your area.
    - You moved away from the program's service area.
    - The carrier or agent materially misrepresented the program or materially breached its terms.

You must give us proof that you had and lost the coverage as described above. If you qualify for coverage under 1. or 2. above, you must apply no earlier than 60 days before your prior coverage is to end and no later than 63 days after that coverage ended. **Note: If you qualify under 1. above, you may apply only for the HCA Medicare supplement plan you had originally. Please complete the questions in Section 3.**

### SECTION 3 – PRIOR COVERAGE

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. (See “Additional Application Periods for All Eligible Applicants” for details.)

**Please answer all questions.**

To the best of your knowledge,

	<b>You</b>	<b>Spouse (if applying)</b>
1. a. Did you turn 65 in the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Did you enroll in Medicare Part B in the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. If yes, what is the effective date? (Please fill in on the card below.)		

All applicants and their spouses, if applying, **must** fill in the boxes on the cards below with the information printed on their Medicare cards or include photocopy.  
We cannot process your application without this information.

**You**

**HEALTH INSURANCE**

NAME OF BENEFICIARY

MEDICARE CLAIM NUMBER

IS ENTITLED TO

EFFECTIVE DATE

Part A Hospital Insurance

/  /

Part B Medical Insurance

/  /

**Spouse (if applying)**

**HEALTH INSURANCE**

NAME OF BENEFICIARY

MEDICARE CLAIM NUMBER

IS ENTITLED TO

EFFECTIVE DATE

Part A Hospital Insurance

/  /

Part B Medical Insurance

/  /

	<b>You</b>	<b>Spouse (if applying)</b>
2. <u>Medicaid</u> is a public aid program for people with low income. <u>It is not the same as Medicare.</u> Are you covered for medical assistance through the state <u>Medicaid</u> program? Note to applicant: If you are participating in a “Spend-Down Program” and have not met your “Share of Cost,” please answer NO to this question.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Will <u>Medicaid</u> pay your premiums for this Medicare supplement coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Do you receive any benefits from <u>Medicaid</u> other than payments toward your Medicare Part B premium?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>(Important Note:</b> If you are receiving any kind of <u>Medicaid</u> assistance, you are not eligible to apply for this program.)		
3. a. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, a PACE plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave “End” blank.	Start: <input type="text"/> / <input type="text"/> / <input type="text"/> End: <input type="text"/> / <input type="text"/> / <input type="text"/>	Start: <input type="text"/> / <input type="text"/> / <input type="text"/> End: <input type="text"/> / <input type="text"/> / <input type="text"/>

	You	Spouse (if applying)
b. If you are still covered under the Medicare plan in 3.a., do you intend to replace your current coverage with this new Medicare supplement plan? ( <b>Important Note:</b> If you do not intend to replace your other Medicare plan, you are not eligible to apply for this program. Your new Medicare supplement plan cannot take effect while a Medicare Advantage plan is still in force.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Was this your first time in this type of Medicare plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Did you drop a Medicare supplement policy to enroll in the Medicare plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. a. Do you have another Medicare supplement policy or certificate in force?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. If so, with which company and what plan do you have?		
Company ►	_____	_____
Plan (A, B, C etc.) ►	_____	_____
c. If so, do you intend to replace your current Medicare supplement policy with this coverage? ( <b>Important Note:</b> If you do not intend to replace all other Medicare supplement coverage, you are not eligible to apply for this program.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union or individual plan)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If so, with which company and what kind of policy?		
Company ►	_____	_____
Type of Policy ►	_____	_____
b. What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "End" blank.)	Start: _____ End: _____	Start: _____ End: _____

#### SECTION 4 – INFORMATION YOU NEED TO KNOW

- A. Did you receive a copy of the Outline of Coverage? ☐ Yes ☐ No
- B. Would you like to receive a copy of Medicare's "Choosing a Medigap Policy" guide? ☐ Yes ☐ No
- C. You do not need more than one Medicare supplement contract.
- D. If you purchase this coverage, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- E. If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement contract.

- F. If, after purchasing this plan, you become entitled to Medicaid, the benefits and premiums under your Medicare supplement contract can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement plan (or, if that is no longer available, a substantially equivalent plan) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement plan provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your plan was suspended, the reinstituted plan will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- G. If you are eligible for and have enrolled in a Medicare supplement plan by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement plan can be suspended, if requested, while you are covered under the employer or union-based group health benefit plan. If you suspend your Medicare supplement plan under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement plan (or, if that is no longer available, a substantially equivalent plan) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- H. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement coverage and concerning medical assistance through the state Medicaid program, including benefits as a "Qualified Medicare Beneficiary" (Q.M.B.) and a "Specified Low-Income Medicare Beneficiary" (S.L.M.B.).

## SECTION 5 – BILLING

(STATE RESIDENTS ONLY -- DOES NOT APPLY TO PEBB OR K-12 RETIREES)

Please indicate your desired payment option (please do not send a payment at this time):

- ☐ Monthly Billing
- ☐ Monthly Automatic Funds Transfer (A.F.T.)

If you select the A.F.T. payment option you must sign and date the enclosed Automatic Funds Transfer Authorization form, and include a deposit slip or voided check from the account you will be using for payment.

## SECTION 6 – SIGNATURE

I hereby apply for the Premera Blue Cross Group Medicare Supplement Plan, and agree to the terms of the contract offered. I understand that I must meet the applicable eligibility requirements and apply within the time limits that are shown on this form. ☒ **Yes** ☐ **No**. I understand that Premera Blue Cross may collect, use and disclose personal information about me as required or permitted by law to perform routine business functions, such as determining my eligibility for enrollment and benefits, paying claims and fulfilling other obligations stated in its contract with the Health Care Authority. If Premera Blue Cross discloses my personal information for any other reason, Premera Blue Cross will first remove any data that can be used to easily identify me or will get my signed authorization. I represent that the foregoing statements and answers are complete and true. I understand that all rights to payment of medical claims by Premera Blue Cross are void if any statement made by me herein is found to be false or incomplete. I understand that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

X	X
Applicant Signature	Spouse Signature
Date	Date

## **CHECK LIST**

**To help us process your application faster, please take a moment to make sure that you have completed the following steps before you send your application.**

1. You must be enrolled (or have proof of enrollment) in both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
2. Fill in the sample Medicare card with the information on your own Medicare card or provide a copy of your Medicare card. We cannot process your application without your Medicare information.
3. You must answer all enrollment questions to the best of your knowledge.
4. Sign the application.
5. Include a copy of the certificate of coverage from prior insurer if needed to confirm prior coverage. If you are under 65, please include a copy of your Award Notice if needed (see Section 2).

# Medicare Advantage Plan Election Form

**C**

Please fill in all information requested. Be sure to read the back of this form.

<b>Retiree/Spouse Information</b>	Social Security Number		Last Name (as appears on Medicare card)		First Name Middle Initial		Home Phone (     )		
	Permanent Residential Address				<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Mo/Day/Yr) /   /   (Mo/Day/Yr)		<input type="checkbox"/> Married /   /	
	City		State		ZIP Code +4		County (Residence)		
	Mailing Address (if different than above)		City		State		ZIP Code +4		
<b>Retiree/Spouse</b>	Relationship <b>SPOUSE</b>		Last Name		First Name Middle Initial		Social Security Number		
							Date of Birth (Mo/Day/Yr) /   /		
		Permanent Residential or Mailing Address (if different from above)				City		State ZIP Code +4	
<b>Medicare Retiree</b>	Retiree Name				Spouse Name				
	Medicare Claim Number - - - - -				Medicare Claim Number - - - - -				
<b>Spouse</b>	Is entitled to Effective Date Effective Date				Is entitled to Effective Date Effective Date				
	Hospital (Part A) / / Medical (Part B) / /				Hospital (Part A) / / Medical (Part B) / /				
<b>PCP and Plan Choice</b>	I wish to enroll in: <input type="checkbox"/> Group Health Medicare Advantage Classic <input type="checkbox"/> Group Health Medicare Advantage Value <input type="checkbox"/> Kaiser Permanente Senior Advantage Classic <input type="checkbox"/> Kaiser Permanente Senior Advantage Value <input type="checkbox"/> Secure Horizons Classic <input type="checkbox"/> Secure Horizons Value I wish to cancel my current medical coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No				I wish to enroll in: <input type="checkbox"/> DeltaCare—Dentist or clinic code _____ <input type="checkbox"/> Regence BlueShield Columbia Dental Plan Clinic location _____ <input type="checkbox"/> Uniform Dental Plan				
	Name of Contracting Primary Care Physician (PCP) (refer to Provider Directory) _____ Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No				Name of Contracting Primary Care Physician (refer to Provider Directory) _____ Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Medical Information</b>	<b>1. Do you currently have end-stage renal disease (kidney disease)?</b> Retiree: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you currently a member of PacifiCare of Oregon/Washington? Retiree: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No				<b>Note:</b> Your answers to questions #3 and #4 below will <b>not</b> affect your eligibility to enroll in a Medicare Advantage plan.				
	<b>2. Do you have any health insurance other than Medicare?</b> Retiree: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, through which company? _____ What type of policy? _____ Do you intend to discontinue this policy? Retiree: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No				<b>3. Do you live in an institution?</b> Retiree: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of institution _____ Address _____ Phone number _____ Date of admission _____				
<b>Signature and Authorization</b>	<b>4. Are you currently receiving Medicaid?</b> Retiree: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Medicaid #: _____								
	I authorize Department of Retirement Systems to deduct from my retirement allowance the amount required to pay for this coverage. <input type="checkbox"/> Yes, deduct from my pension <input type="checkbox"/> No, I will send my payment monthly I certify that to the best of my knowledge, I must maintain _____ My signature below warrants that I have read and understand this Medicare Advantage Plan Election Form, including the Statement of Understanding on the _____'s Evidence of Coverage document for _____ your selected Medicare Advantage Evidence of Coverage document will be sent to you upon receipt of your enrollment by the plan.								
Signature of Applicant (see Privacy Notice on back)				Date		Signature of Spouse		Date	
Signature of individual who assisted the applicant and/or spouse in completing this form				Date		Relationship to Applicant/Spouse			
<input type="checkbox"/> If Durable Power of Attorney for Health Care (DPAHC) for applicant and/or spouse, indicate here and attach certificate or other written proof of legal guardianship.									
<b>Return to:</b> Washington State Health Care Authority; P.O. Box 42684; Olympia, WA 98504-2684									

## STATEMENT OF UNDERSTANDING

I understand that beginning on my effective date with the Medicare Advantage plan I have selected on the reverse of this form, all medical services, with the exception of emergency, or out-of-area urgently needed services, must be provided or arranged for by the plan. Services rendered without prior authorization of my Medicare Advantage contracting primary care physician (PCP) will not be reimbursed by the plan or Medicare, except for emergency services anywhere in the world or urgently needed services outside the plan's service area (or under unusual and extraordinary circumstances, provided when I am in the service area, but my contracting medical group is temporarily unavailable or inaccessible).

I understand that I can be a member of only one Medicare Advantage coordinated care plan at any time. By enrolling in the Medicare Advantage plan I have selected, I will automatically be disenrolled by the Centers for Medicare & Medicaid Services (CMS) from any other Medicare Advantage coordinated care plan of which I may be a member.

By enrolling in the Medicare Advantage plan, I authorize the CMS to provide information to the Medicare Advantage plan I select confirming my entitlement for Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B) under Title XVIII (the Medicare Program) of the Social Security Act. I understand that I must maintain my Medicare Part A and Part B insurance by continuing to pay the Part B premiums and the Part A premiums, if applicable. I also authorize the Medicare Advantage plan's provider or any other holder of medical or other relevant information about me to release to CMS or CMS's agents any information needed to administer Title XVIII of the Social Security Act.

I HEREBY AUTHORIZE any person including—but not limited to—physicians, hospitals, insurance companies and other organizations to release any information acquired by such person in the course of examination or treatment of myself, which is relevant to the provision of or coordination of benefits or the professional review activities.

I understand that it is my responsibility to inform the Medicare Advantage plan I have selected prior to either permanently moving out of the service area or leaving the service area for more than twelve (12) months, and that my absence means the plan must disenroll me and return me to the original Medicare coverage.

I understand that I may disenroll from this Medicare Advantage plan by sending a written request to the Medicare Advantage plan I have selected, the Social Security Office, or the Railroad Retirement Board. Until confirmation of the effective date of disenrollment, I must continue to receive health care from the Medicare Advantage plan providers.

I understand that as a member of the Medicare Advantage plan, I have the right to appeal service and payment denials made by the plan.

I understand that my enrollment in the Medicare Advantage plan I have selected is effective with my date of retirement or January 1, if enrolling during the Public Employees Benefits Board (PEBB) annual open enrollment period. I understand that upon confirmation from CMS, the Medicare Advantage plan will send me written notice of my effective date. As of my enrollment effective date, all of my routine health care must be provided for by plan-contracting medical providers.

**Note:** Until you have received this written notification, you should not drop any supplemental insurance you have in effect now.

This form represents your temporary Medicare Advantage plan identification card. Until you receive your Medicare Advantage identification card, please keep it with you and present it each time you require services from a contracted provider. Whenever possible, the Medicare Advantage organization provides the member, prior to the effective date, evidence of health insurance coverage so that (s)he may begin using the plan services as of the effective date.

# 2007 PEBB Retiree Monthly Rates

Effective January 1, 2007

## Special Requirements

1. To qualify for the Medicare rate, you must be enrolled in both Parts A and B of Medicare.
2. Medicare-enrolled subscribers in Group Health Cooperative's Medicare Advantage plan, Kaiser Permanente Senior Advantage, or PacifiCare Secure Horizons must agree to complete and sign the *Medicare Advantage Plan Election Form* to enroll in one of these plans. For more information on these requirements, please contact your health plan's customer service department.

Medical Plans									
Subscribers not eligible for Medicare (or enrolled in Part A only):	Community Health Plan Classic	Group Health Classic	Group Health Value	Kaiser Permanente Classic	Kaiser Permanente Value	Secure Horizons Classic	Secure Horizons Value	Regence Classic	Uniform Medical Plan
<b>Subscriber Only</b>	\$ 471.32	\$ 427.37	\$ 383.15	\$ 439.92	\$ 401.10	N/A	N/A	\$ 508.80	\$ 393.78
<b>Subscriber &amp; Spouse</b>	935.41	847.51	759.07	872.61	794.97	N/A	N/A	1,010.37	780.33
<b>Subscriber &amp; Child(ren)</b>	819.39	742.48	665.09	764.44	696.50	N/A	N/A	884.98	683.69
<b>Full Family</b>	1,283.48	1,162.62	1,041.01	1,197.73	1,090.37	N/A	N/A	1,386.55	1,070.24
Subscribers enrolled in Parts A & B of Medicare:									
<b>Subscriber Only</b>	281.72	179.45	152.15	157.00	121.16	\$175.51	128.41	360.29	186.33
<b>Subscriber &amp; Spouse (1 eligible)</b>	745.81	599.59	528.07	589.69	515.03	N/A	N/A	861.86	572.88
<b>Subscriber &amp; Spouse (2 eligible)</b>	556.21	351.67	297.07	306.77	235.09	343.79	249.59	713.35	365.43
<b>Subscriber &amp; Child(ren)</b>	629.79	494.56	434.09	481.52	416.56	N/A	N/A	736.47	476.24
<b>Subscriber &amp; Child(ren) (2 eligible)</b>	556.21	351.67	297.07	306.77	235.09	343.79	249.59	713.35	365.43
<b>Full Family (1 eligible)</b>	1,093.88	914.70	810.01	914.21	810.43	N/A	N/A	1,238.04	862.79
<b>Full Family (2 eligible)</b>	904.28	666.78	579.01	631.29	530.49	N/A	N/A	1,089.53	655.34
<b>Full Family (3 eligible)</b>	830.70	523.89	441.99	456.54	349.02	512.07	370.77	1,066.41	544.53

Medicare rates shown above have been reduced by the state-funded contribution of \$149.67 per retiree per month.

<b>Medicare Supplement Plans*</b>				
	<b>Premera Blue Cross</b>			
	<b>Plan E Retired</b>	<b>Plan E Disabled</b>	<b>Plan J Retired without Rx</b>	<b>Plan J Disabled without Rx</b>
<b>Subscriber Only</b>	\$ 68.29	\$111.03	\$ 88.93	\$146.11
<b>Subscriber &amp; Spouse (1 eligible)**</b>	454.84	497.58	475.48	532.66
<b>Subscriber &amp; Spouse (2 eligible - 1 retired, 1 disabled)</b>	172.09	172.09	227.81	227.81
<b>Subscriber &amp; Spouse (2 eligible)</b>	129.35	214.83	170.63	284.99
<b>Subscriber &amp; Child(ren) (1 eligible)**</b>	358.20	400.94	378.84	436.02
<b>Full Family (1 eligible)**</b>	744.75	787.49	765.39	822.57
<b>Full Family (2 eligible - 1 retired, 1 disabled)**</b>	462.00	462.00	517.72	517.72
<b>Full Family (2 eligible)**</b>	419.26	504.74	460.54	574.90

Medicare rates shown above have been reduced by the state-funded contribution of \$149.67 per retiree per month.

\* If a Medicare supplement plan is selected, non-Medicare eligible dependents are enrolled in the Uniform Medical Plan (UMP). The rates shown reflect the total rate due, including both the Medicare supplement and the UMP premiums.

\*\* Plan J with Rx is no longer available to new subscribers.

<b>Dental Plans with Medical Plan</b>	<b>DeltaCare, administered by Washington Dental Service</b>	<b>Regence BlueShield Columbia Dental Plan</b>	<b>Uniform Dental Plan</b>
<b>Subscriber Only</b>	\$ 33.36	\$ 45.63	\$ 38.59
<b>Subscriber &amp; Spouse</b>	66.72	91.26	77.18
<b>Subscriber &amp; Child(ren)</b>	66.72	91.26	77.18
<b>Full Family</b>	100.08	136.89	115.77

## **Retiree Life Insurance Self-Pay Rate - \$2.19 per month**

# PEBB Life Insurance Conversion

When you terminate your employment or retire, you are entitled to convert your Public Employees Benefits Board (PEBB)-sponsored group life insurance policy to an individual whole life policy. You may do this *without providing proof of good health* when your coverage ends or is reduced under the group plan sponsored by the PEBB. You can also convert the group life coverage on your family members to individual whole life policies for each covered dependent. See your PEBB life insurance booklet for further details or call a customer service representative at ReliaStar Life Insurance Company (1-866-689-6990).

To apply for conversion of your group life insurance, fill out and mail the bottom part of this form to ReliaStar Life Insurance Company. **To protect your right of conversion, this form must be postmarked no later than 31 days (if you are terminating**

**employment) or 60 days (if you are retiring) following the date your group coverage terminates.** When your application is received by ReliaStar, you should expect to receive the company's conversion application within 15 days.

Provided that you apply on time and pay your first premium, the converted policy will take effect either 31 days (for terminating employees) or 60 days (for retiring employees) after the date of termination of your group coverage. **You are covered by the group plan during the 31-day or 60-day conversion period, as long as premiums are paid.** You will be billed directly by ReliaStar Life Insurance Company for all premium payments retroactive to the date your group term life coverage ended. In addition, the company will provide all policy service you may require directly. The Health Care Authority will not be involved.



## For terminating or retiring employees of PEBB-sponsored plans

I am interested in the conversion option described in my Group Insurance Certificate. Please furnish information and the necessary forms.				
Employee's name		Social security number — —	Date of birth	
Spouse's/same-sex domestic partner's name (Complete only if you are interested in converting his or her insurance.)			Date of birth	
Phone number	State agency or institution	<b>Reason for Conversion</b> <input type="checkbox"/> Retiring      Date _____ <input type="checkbox"/> Resigning      Date _____ <input type="checkbox"/> Other      Date _____ If other, state reason _____ _____		
Address				Apt./unit number
City, county, state, and ZIP Code				
<b>Note:</b> If you are disabled and qualify for the waiver of premium benefit, check this box. <input type="checkbox"/>				
Date	Signature			

Washington State law may require disclosure of any information you submit as a public record.  
The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or  
online at [www.pebb.hca.wa.gov](http://www.pebb.hca.wa.gov).



HCA 50-801 (1/07)

**Washington State  
Health Care Authority**

*Public Employees Benefits Board*

P.O. Box 42684

Olympia, WA 98504-2684

Change Service Requested

## **READ NOW**

**You have 60 days after the postmark to elect to  
continue your PEBB health coverage.**